UUP Productivity Enhancement Program for 2016 – Enrollment Form

Name_____ Last 4 digits of SS#_____

Health Insurance Plan _____

Individual [ ] or Family Coverage [ ] (CHECK ONE)

By signing this document, I elect to participate in the 2016 portion of the Productivity Enhancement Program (PEP) and agree to the provisions contained in the Productivity Enhancement Program Description (hereafter Program Description) that is available in my campus Human Resources Office. I understand that I must meet the eligibility criteria explained in the Program Description in order to participate.

I understand that employees will surrender either 2 or 3 days of Annual leave as a result of participation in the program. I understand that ALL of these leave credits will be deducted from my leave balances at the time my enrollment is processed. Furthermore, I understand that no portion of this leave will be returned to me under any circumstances.

In exchange for forfeiting this accrued leave I will receive a health insurance contribution credit (hereafter "credit") to be applied against the employee share cost of NYSHIP health insurance premiums paid in the 2016 NYSHIP plan year. The maximum possible amount of this credit is $500. Pursuant to the program description, the amount of this credit will be established at the time of enrollment and will be adjusted only upon movement between individual and family coverage. I understand that I will not receive any amount of credit that exceeds the cost of the employee share of my NYSHIP health insurance premiums paid during that period.

I understand that this enrollment form only applies to the 2016 NYSHIP plan year. I understand that in order to participate, this completed election form must be filed with my campus Human Resources Office by the close of business on **November 27, 2015**.

Signature_____ Date_____

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

This information is being requested pursuant to New York State Civil Service Law section 161-a for the principal purpose of determining eligibility for the Productivity Enhancement Program for 2016. This information will be used in accordance with Public Officers Law section 96(1). Failure to provide this information may result in a denial of eligibility to participate in the Productivity Enhancement Program for 2016. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, contact pio@cs.state.ny.us.

For Agency Human Resources Office Only:

Full-time_____ Part-time_____ (check one)

Days of annual leave deducted from employee's balance: _____ Date_____

Verification of eligibility. I certify that this applicant meets the eligibility criteria necessary for participation in this program.

Name_____ Title_____

Signature_____ Date_____

For Health Benefits Administrators Only:

Date Processed_____

Biweekly Health Insurance Contribution Credit_____

Name_____ Title_____

Signature_____ Date_____