Productivity Enhancement Program for 2025
Enrollment Form

Name_____ Salary Grade_____ SS# xxx-xx-_____
Health Insurance Plan _____
Individual ☐or Family Coverage ☐(CHECK ONE)

By signing this document, I elect to participate in the 2025 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 agency personnel office. I understand that I must meet all the eligibility criteria as set forth in the program description in order to participate.

I understand that, in accordance with the program description, I will surrender leave accruals standing to my credit as a result of participation and 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. I wish to apportion this leave forfeiture as follows:

BARGAINING UNIT AND GRADE	**FORFEITURE: NUMBER OF DAYS AND HOURS**
Council 82, CSEA, DC-37, NYSCOPBA, PBANYS, PEF and M/C – Salary Grade 1–17	Choose 4 or 8 days_____ Hours: vacation leave_____ personal leave_____
Council 82, CSEA, DC-37, NYSCOPBA, PBANYS, PEF – Salary Grade 18–24, M/C – Salary Grade 18-23	Choose 2.5 or 5 days _____ Hours: vacation leave_____ personal leave_____
PEF Institution Teachers Salary Grade 1–17	Choose between 1 to 8 days _____ Hours: personal leave_____ floating holiday_____ compensatory time_____
PEF Institution Teachers Salary Grade 18–24	Choose between 1 to 5 days_____ Hours: personal leave_____ floating holiday_____ compensatory time_____

In exchange for forfeiting this accrued leave I will receive a credit as set forth in the program description to be applied against the employee share cost of 2025 plan year NYSHIP health insurance. 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 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 is for the 2025 program year only. I also understand that, in order to participate this completed election form must be filed with my agency personnel office by the close of business on **December 9, 2024.**

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 2025. 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 2025. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375

For Agency Personnel Office Only:
Employee's payroll/employment percentage: _____ Salary Grade: _____ Total number of days forfeited: _____
Hours deducted from employee's balance: vacation_____ personal_____ floating holiday_____ compensatory time_____
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 Premium Contribution Credit: _____
Name_____ Title_____
Signature_____ Date_____

Copy 1 – Health Benefits Administrator
Copy 2 – Personnel Office/Attendance Records