Productivity Enhancement Program for 2004 – Enrollment Form

Name____ SS#__________________
Health Insurance Plan____
Individual [ ] or Family Coverage [ ] (CHECK ONE)

By signing this document, I elect to participate in the 2004 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 the eligibility criteria elaborated in the Program Description in order to participate.

I understand that full-time employees will surrender 0.75 day (i.e., 5.75 or 6 hours for 37.5 and 40 hour workweeks, respectively) of vacation and/or personal leave as a result of participation (prorated for eligible part-time and hourly employees) 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:

_________ **Hours of Vacation Leave** _________**Hours of Personal Leave**

In exchange for forfeiting this accrued leave I will receive a health insurance contribution credit (hereafter "credit") of up to $100 to be applied against the employee share cost of NYSHIP health insurance premiums paid between September 30, 2004 and December 31, 2004. 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 my participation in this program automatically ends on December 31, 2004 and that I will be required to submit a new enrollment form if I wish to participate during 2005.

I understand that in order to participate this completed election form must be filed with my agency personnel office by the close of business on August 27, 2004.

Signature____ Date____________

For Agency Personnel Office Only:

Employee's payroll/employment percentage:________________

Hours of leave deducted from employee's balance:
Vacation________ Personal________ 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__________________________

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