Productivity Enhancement Program for 2005 – Enrollment Form

Name_____ SS#_____
Health Insurance Plan_____
Individual [ ] or Family Coverage [ ] (CHECK ONE)

By signing this document, I elect to participate in the 2005 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, in accordance with the program description (and Appendix for Institution Teachers as appropriate) 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:

Hours of Vacation Leave_____ **Hours of Personal Leave _____**

In exchange for forfeiting this accrued leave I will receive a credit of up to $400 to be applied against the employee share cost of NYSHIP health insurance premiums in each program year (as specified in the program description and Appendix for Institution Teachers as appropriate). 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 2005 program year only, and that I will be required to submit a new enrollment form if I wish to participate in the 2006 program year.

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 October 29, 2004.

Signature_____ Date_____

For Agency Personnel Office Only:

Employee's payroll/employment percentage: _____

Total number of days forfeited: _____

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