

Productivity Enhancement Program for 2024 Enrollment Form for UUP and MC-represented Employees

Last Name: _____ First Name: _____

Bargaining Unit: UUP MC

Health Insurance Plan: BlueCross BlueShield of WNY Empire Plan Independent Health

Type of Coverage: Individual Family

By signing this document, I elect to participate in the 2024 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 the Human Resource Management/Employee Benefits Office. I understand that I must meet the eligibility criteria explained in the Program Description in order to participate.

I understand that full-time employees with an annual salary of \$76,028 and below will surrender either 4 days or 8 days of vacation leave in return for a credit of up to \$800 or \$1600 to be applied toward the employee share of NYSHIP premiums deducted from biweekly paychecks issued in 2024, and full-time employees earning more than \$76,028 and up to \$108,646 will surrender either 2.5 or 5 days of vacation leave in return for a credit of up to \$750 or \$1500 to be applied toward the employee share of NYSHIP premiums deducted from biweekly paychecks issued in 2024. I understand that part-time employees will forfeit vacation leave on a prorated basis in accordance with their payroll/employment percentage in return for a prorated credit. I understand that ALL of these leave credits will be deducted from my leave balances at the time my enrollment is processed. I understand that no portion of this leave will be returned to me under any circumstances.

I wish to surrender _____ day(s) of vacation leave. In exchange for surrendering 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 biweekly paycheck issued in 2024. The maximum possible amount of this credit for full-time employees is \$1600. The maximum deducted from credit for part-time employees will be prorated based upon the employee's payroll/employment percentage. 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 premiums paid during this period.

I understand that this enrollment form is for the 2024 program year only. I understand that in order to participate, this completed election form must be **returned to Human Resource Management/Employee Benefits Office, 410 Cleveland Hall, by the close of business on Monday, December 11, 2023.**

Employee 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 2024. This information will be used in accordance with Public Officer Law section 96(1). Failure to provide this information may result in a denial of eligibility to participate in the Productivity Enhancement Program for 2024. 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 Personnel Office only:

Full-time: _____ Part-time: _____ (check one) Days of annual leave to be deducted employee's from balance: _____

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

Name Sherry L. Wagner

Title HR Generalist

Signature _____

Date _____

For Payroll/Time and Attendance

Name Maureen Malott

Title Senior Staff Assistant

Signature _____

Date _____

For Health Benefits Administrators Only:

Date Processed _____ Biweekly Health Insurance Contribution Credit _____

Name Lisa Gemmati

Title Administrative Assistant 1

Signature _____

Date _____