

**Productivity Enhancement Program for 2023 Enrollment Form
For CSEA and PEF Represent Employees**

Last Name _____ First Name _____ SUNY ID _____

Health Insurance Plan: Blue Cross/Blue Shield Independent Health Empire Plan (CHECK ONE)
Individual or Family (CHECK ONE)

By signing this document, I elect to participate in the 2023 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 to apportion this leave forfeiture as follows:

Bargaining Unit & Grad Level	Days/Accruals
CSEA and M/C Salary Grade 1-17	Choose 4 or 8 days _____ Hours vacation leave _____ Hours personal leave _____
PEF and DC-37 Salary Grade 1-17	Choose 3 or 6 days _____ Hours vacation leave _____ Hours personal leave _____

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 2023 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 2023 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 12, 2022.

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 2023. 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 2023. 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.

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

For Agency Personnel Office Only:

Employee's payroll/employment percentage: _____ Salary Grade: _____ 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 Maureen Malott Title Senior Staff Assistant
Signature _____ Date _____

For Health Benefits Administrators Only:

Date Processed _____
Biweekly Health Insurance Premium Contribution Credit _____
Name Lisa Gemmati Title Administrative Assistant 1, Benefits Office
Signature _____ Date _____

