

**Productivity Enhancement Program for 2016
Enrollment Form - PEF**

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 2016 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:

	PEF	PEF Institution Teachers
Salary Grade 1–17	Choose 3 or 6 days _____ Hrs vacation leave _____ Hrs personal leave _____	Choose between 1 to 6 days _____ Hrs personal leave _____
Salary Grade 18–24 (to SG 23 for M/C)	Choose 2 or 4 days _____ Hrs vacation leave _____ Hrs personal leave _____	Choose between 1 to 4 days _____ Hrs 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 2016 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 2016 program year only.

I understand that in order to participate this completed election form must be filed with the OGS Business Services Center (BSC) Benefits Unit by the close of business on **January 8, 2016**. If you have any questions, please contact the BSC Benefits Unit at (518) 457-4272, or e-mail BSCBenefitsAdmin@ogs.ny.gov.

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 2016. 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 2016. This information will be maintained by the Business Services Center (BSC) Benefits Unit. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

For OGS BSC Benefits 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 _____ Title _____
 Signature _____ Date _____

For Health Benefits Administrators Only:

Date Processed _____
 Biweekly Health Insurance Premium Contribution Credit _____
 Name _____ Title _____
 Signature _____ Date _____

