2015 PRODUCTIVITY ENHANCEMENT PROGRAM
FOR UUP REPRESENTED EMPLOYEES

Name_____ SUNY ID#_____

Daytime Telephone #_____E-Mail Address_____

By signing this document, I elect to participate in the 2015 portion of the Productivity Enhancement Program (PEP) and agree to the provisions contained in the PEP Description (hereafter Program Description) that is available in the Human Resources Benefits Office (206 Jacobsen Hall). I understand that to be eligible to participate, I must:

- Be an employed on a calendar year or College Year basis;
- Be a full-time employee with an annual salary at or below $90,022 at the time of enrollment; or a part-time employee with an annual full-time equivalent salary below $90,022;
- Be an employee covered by the 2011-2016 New York State UUP Collective Bargaining Agreement;
- Have a minimum vacation balance at the time of election of at least 8 days after making the forfeiture; and
- Be a NYSHIP enrollee (contract holder) in either the Empire Plan or an HMO at the time of enrollment.

I understand that, in accordance with the program description, I will surrender vacation accruals standing to my credit as a result of participation and that ALL credits will be deducted from my leave balances at the time my enrollment is processed (prorated for part time eligible employees). Furthermore, I understand no portion of this leave will be returned to me under any circumstances. I wish to apportion this leave forfeiture as follows:

Salary up to $62,998	3 days _____
Salary between $62,998 and $90,022	2 days _____

In exchange for forfeiting this accrued leave, I will receive a health insurance contribution credit (hereafter "credit") to be applied against the employee share of NYSHIP health insurance premiums paid during the balance of the 2015 NYSHIP plan year. The maximum possible amount of **credit is $500** for full-time employees. The maximum credit for part-time employees will be prorated based upon the employee's payroll/employee 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 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 2015 program year only.

I understand that in order to participate, this completed election form must be filed with the Human Resources Benefits Office (206 Jacobsen Hall) or fax to 464-4390 (Community campus employees may return their completed election form to the Community Human Resources Office 1st Floor) by close of business on 11/28/2014

Signature _____ Date _____

Date Received _____

Payroll Services:

Full Time_____ Part Time_____ If part time, employment percentage: _____

Days of leave deducted from employee's balance:

Vacation _____ Date _____

Date S/L Transaction Entered _____Processed by_____

Human Resources Benefits Office

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

Name _____Kathi Exner_____ Title_____Health Benefits Administrator_____

Signature _____ Date_____

Health Insurance Plan_____ Individual_____ Family_____

Date NYBEAS Transaction Entered_____Health Insurance Premium Credit_____