2025 PRODUCTIVITY ENHANCEMENT PROGRAM
FOR PEF REPRESENTED EMPLOYEES

Name_____ Upstate ID#_____

Daytime Telephone #_____E-Mail Address_____

Health Insurance Plan_____ Individual ☐ or Family Coverage ☐ (CHECK ONE)

By signing this document, I elect to participate in the 2025 portion of the Productivity Enhancement Program (PEP) and agree to the provisions contained in the PEP Description (hereafter Program Description) that is available on the Human Resources Benefits Website. I understand that I must meet all eligibility criteria as set forth in the program description in order to participate. I must:

- Be a PEF represented employee in the Executive branch in a title at Salary Grade 24 or below or equated to a position at or below Salary Grade 24;
- Have a minimum combined balance of vacation and personal leave 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 leave 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 Grade 1 - 17	Hours vacation leave _____ Hours of Personal leave _____
Salary Grade 18 -24	Hours vacation leave _____ Hours of Personal leave _____

In exchange for forfeiting this accrued leave, I will receive a health insurance contribution credit (hereafter "credit") as follows;

- Salary Grade 1 – 17 credit of up to $800 for (4 days) 30 or 32 hours (37.5 or 40 hour workweeks respectively) **or** $1,600 for (8 Days) 60 or 64 hours (37.5 or 40 hour workweeks respectively)
- Salary Grade 18 -24 up to $750 for (2.5 days) 18.75 hours or 20 hours (37.5 or 40 hour workweeks respectively) **or** $1,500 for (5 days) 37.5 or 40 hours (37.5 or 40 hour workweeks respectively)

to be applied against the employee share cost of NYSHIP health insurance premiums. 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 2025 program year only.

I understand that in order to participate, this completed election form must be filed with the Human Resources Benefits Office via interoffice mail to Telergy, Attn: Benefits, or email scanned copy to benefits@upstate.edu, 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 December 9, 2024

Signature _____ Date _____

FOR OFFICE USE ONLY

Date Form Received _____

Payroll Services:

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

Hours of leave deducted from employee's balance:

Vacation _____ Personal _____ 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 _____Kaylee Aseltine_____ Title_____Health Benefits Administrator_____

Date NYBEAS Transaction Entered_____Health Insurance Premium Credit_____ Processed by_____