2025 PRODUCTIVITY ENHANCEMENT PROGRAM FOR UUP 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 Productivity Enhancement Program Description (hereafter Program Description). I understand that I must meet all eligibility criteria below in order to participate.

- Be employed on a Calendar Year or College Year basis;
- Be a full-time employee with an annual salary below $111,905 OR part-time employee whose biweekly salary is within this salary range at the time of enrollment;
- Be an employee covered by the 2022-2026 New York State/UUP Collective Bargaining Agreement;
- Be a NYSHIP enrollee in either the Empire Plan or an HMO;
- Be eligible to receive an employer contribution toward NYSHIP premiums (or be on leave without pay from a position in which the employee is normally eligible for an employer share contribution toward NYSHIP premiums); and
- Have a sufficient annual leave balance (vacation) to make the full leave forfeiture without bringing their annual leave balance below **8 days** or a prorated balance for part-time employees respectively

I understand that part-time employees will forfeit annual 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 apportion this leave forfeiture as follows (check one):

Earnings up to $78,309	4 Days_____ 8 Days_____
Earnings above $78,309 and below $111,905	2.5 Days_____ 5 Days_____

I understand that full-time employees earning up to $78,309 will surrender either 4 days or 8 days of annual leave in return for a credit of up to $800 or $1,600, and full-time employees earning more than $78,309 and below $111,905 will surrender either 2.5 or 5 days of annual leave in return for a credit of up to $750 or $1,500 to be applied toward the employee share of NYSHIP premiums deducted from biweekly paychecks issued in 2024.

The maximum 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 health insurance premiums paid during that period.

I understand that in this enrollment only applies to the 2025 NYSHIP plan year. 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 _____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_____