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# **2020 Productivity Enhancement Program (PEP)**

**United University Professions (UUP) BU-08**

**Management Confidential – MC-13**

## HSC & West Campus Employees Enrollment Form

**Enrollment Period 10/14/2019 through 11/15/2019**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name (Please print)** | | | Employee ID or State ‘N’ Number | | | | | | Department |
| Indicate Status   * **FT** * **PT FTE\_\_\_\_** | | Covered (Check One)   * **Individual** * **Family** | | | | | Bargaining Unit   * **UUP – 08** * **MC-13** | | |
| By signing this document, I elect to participate in the 2020 Productivity Enhancement Program (PEP) and agree to the provisions contained in the PEP description. I understand that I must meet the eligibility criteria in order to participate.  I understand that, in accordance with the program description, I will forfeit leave accruals in exchange for a credit to be applied to my NYSHIP premium on a biweekly basis. 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 elect to forfeit my leave as follows: | | | | | | | | | |
| **Salary up to $69,556** | | | |    **Vacation Leave 3.0 days**  **6.0 days** | | | | | |
| **Salary from $69,556 up to $99,397** | | | |     ** Vacation Leave 2.0 day**  ** 4.0 days** | | | | | |
| In exchange for forfeiting this accrued leave, I will receive a health insurance contribution credit to be applied against my employee share cost of NYSHIP health insurance premiums paid in the 2020 plan year. 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 only applies to the 2019 NYSHIP plan year. I will be required to submit a separate enrollment form each year I wish to participate. For 2020, my completed form must be submitted *by November 15, 2019 close of business to:*  **HUMAN RESOURCE SERVICES**, **ROOM 390, ADMINISTRATION BUILDING**, **Zip = 0751,**  **Attention: Louann Hondropulos** | | | | | | | | | |
| **Employee Signature** | | | | | | **Date** | | | |
| **FOR HUMAN RESOURCE USE ONLY**  I certify that this application meets the eligibility criteria necessary for participation in the program. | | | | | **FOR BENEFITS USE ONLY** | | | | |
| **Vacation days forfeited** |  | | | | **Health Insurance Premium Credit** | | | | |
| **Signature** | **Date Processed** | | | | **Signature** | | | **Date Processed** | |