

***Productivity Enhancement Program for 2010 — Enrollment Form***

Name \_\_\_\_\_ SS# (last 4) \_\_\_\_\_

Health Insurance Plan \_\_\_\_\_

Individual  or Family Coverage  (CHECK ONE)

By signing this document, I elect to participate in the 2010 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 the eligibility criteria elaborated in the Program Description in order to participate.

I understand that, I understand that full-time employees will surrender 3 days of Annual leave as a result of participation in the program and that part-time employees will surrender 1 day as a result of participation. Furthermore I understand 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:

In exchange for forfeiting this accrued leave I will receive a credit of up to \$500 to be applied against the employee share cost of 2010 plan year NYSHIP health insurance premiums (as specified in the program description). 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 2010 program year only.

I understand that in order to participate this completed election form must be filed with my agency personnel office by the close of business on ***November 27, 2009***

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**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 2008. 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 2008. This information will be maintained by the employee's Agency Personnel Office. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

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**For Agency Personnel Office Only:**

Employee's payroll/employment percentage: \_\_\_\_\_

Total number of days forfeited: \_\_\_\_\_

Days of annual leave deducted from employee's balance: \_\_\_\_\_

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

Name Deb Thompson Title Calculations Clerk II

Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Health Benefits Administrators Only:**

Date Processed \_\_\_\_\_

Biweekly Health Insurance Premium Contribution Credit \_\_\_\_\_

Name Matt Vanderwerf Title Personnel Associate

Signature \_\_\_\_\_ Date \_\_\_\_\_