



Human Resource Services

2012 Management Confidential (MC-13) Productivity Enhancement Program (PEP) HSC & West Campus Employees Enrollment Form

Enrollment Period 10/31/11 through 12/5/11

Name (Please print)		Social Security Number		Department	
Indicate Status <input type="checkbox"/> FT <input type="checkbox"/> PT FTE _____	Agency Code 28050	Health Insurance Plan <input type="checkbox"/> Empire Plan - 001 <input type="checkbox"/> H.I.P. – 050 <input type="checkbox"/> Aetna – 210 <input type="checkbox"/> Empire Blue Cross/Shield HMO	Covered (Check One) <input type="checkbox"/> Individual <input type="checkbox"/> Family	Bargaining Unit <input type="checkbox"/> M/C -13	
<p>By signing this document, I elect to participate in the 2012 Productivity Enhancement Program (PEP) and agree to the provisions contained in the Productivity Enhancement Program Description that is available in the Human Resource Services office. I understand that I must meet the eligibility criteria elaborated in the Program Description in order to participate.</p> <p>I understand that participating full-time employees will surrender either 3 days of vacation leave or 6 days of vacation leave (prorated for eligible part-time), and 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.</p> <p style="text-align: center;">_____ 3 vacation days _____ 6 vacation days</p> <p>In exchange for forfeiting this accrued leave, I will receive a health insurance contribution credit of up to \$500 (\$19.23 bi-weekly credit) or \$1000 (\$38.46 bi-weekly) to be applied against the employee share cost of NYSHIP health insurance premiums paid between January 4, 2012 and December 19, 2012. 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.</p> <p>I understand that my participation in this program automatically ends December 31, 2012. I understand that I will be required to submit a new enrollment form during the applicable enrollment period for each program year that I wish to participate.</p> <p>I understand that in order to participate this completed enrollment form must be filed <u>by the close of business on December 5, 2011</u> with HUMAN RESOURCE SERVICES, located on WEST CAMPUS, ROOM 390, ADMINISTRATION BUILDING, Zip = 0751, Attention: Louann Hondropulos</p>					
Employee Signature			Date		
FOR HUMAN RESOURCE USE ONLY Verification of eligibility. I certify that this application meets the eligibility criteria necessary for participation in this program			FOR BENEFITS USE ONLY		
Vacation used		Health Insurance Premium Credit			
Signature	Date Processed	Signature	Date Processed		

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