

**Productivity Enhancement Program for 2026
Enrollment Form**

Name _____ Salary Grade _____ SS# xxx-xx-_____
 Health Insurance Plan _____
 Individual or Family Coverage (CHECK ONE)

By signing this document, I elect to participate in the 2026 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 all the eligibility criteria as set forth in the program description in order to participate.

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 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:

BARGAINING UNIT AND GRADE	FORFEITURE: NUMBER OF DAYS AND HOURS
Council 82, CSEA, DC-37, NYSCOPBA, PBANYS, PEF and M/C – Salary Grade 1–17	Choose 4 or 8 days _____ Hours: vacation leave _____ personal leave _____
Council 82, CSEA, DC-37, NYSCOPBA, PBANYS, PEF – Salary Grade 18–24, M/C – Salary Grade 18-23	Choose 2.5 or 5 days _____ Hours: vacation Leave _____ personal leave _____
PEF Institution Teachers Salary Grade 1–17	Choose between 1 to 8 days _____ Hours: personal leave _____ floating holiday _____ compensatory time _____
PEF Institution Teachers Salary Grade 18–24	Choose between 1 to 5 days _____ Hours: personal leave _____ floating holiday _____ compensatory time _____

In exchange for forfeiting this accrued leave I will receive a credit as set forth in the program description to be applied against the employee share cost of 2026 plan year NYSHIP health insurance. 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 2026 program year only. I also understand that, in order to participate this completed election form must be filed with my agency personnel office by the close of business on **December 8, 2025.**

Signature _____ Date _____

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 2026. 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 2026. 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

For Agency Personnel Office Only:

Employee's payroll/employment percentage: _____ Salary Grade: _____ Total number of days forfeited: _____
 Hours deducted from employee's balance: vacation _____ personal _____ floating holiday _____ compensatory time _____
 Date: _____

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

Name _____ Title _____
 Signature _____ Date _____

For Health Benefits Administrators Only:

Date Processed: _____
 Biweekly Health Insurance Premium Contribution Credit: _____
 Name _____ Title _____
 Signature _____ Date _____