



**2024 Productivity Enhancement Program (PEP)
United University Professions (UUP) BU-08
Management Confidential – MC-13
HSC & West Campus Employees Enrollment Form
Enrollment Period 11/1/2023 through 12/11/2023**

Name (Please print)		Employee ID or State 'N' Number		Department
Indicate Status <input type="checkbox"/> FT <input type="checkbox"/> PT FTE _____		Covered (Check One) <input type="checkbox"/> Individual <input type="checkbox"/> Family		Bargaining Unit <input type="checkbox"/> UUP – 08 <input type="checkbox"/> MC-13
<p>By signing this document, I elect to participate in the 2023 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.</p> <p>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:</p>				
Salary up to \$76,028		Vacation Leave <input type="checkbox"/> 4.0 days <input type="checkbox"/> 8.0 days		
Salary from \$76,028 up to \$108,646		Vacation Leave <input type="checkbox"/> 2.5 day <input type="checkbox"/> 5.0 days		
<p>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 2024 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.</p> <p>I understand that this enrollment form only applies to the 2024 NYSHIP plan year. I will be required to submit a separate enrollment form each year I wish to participate. For 2024, my completed form must be submitted <u>by December 11, 2023 close of business to:</u></p> <p align="center">HRS_TimeAtt@stonybrook.edu or Fax to 631-632-4989 Attention: Louann Hondropulos</p>				
Employee Signature			Date	
FOR HUMAN RESOURCE USE ONLY		FOR BENEFITS USE ONLY		
I certify that this application meets the eligibility criteria necessary for participation in the program.				
Vacation days forfeited		Health Insurance Premium Credit		
Signature	Date Processed	Signature	Date Processed	