New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan

Change of Name/Address

Helpline: 800-422-8463 • nysdcp.com

Personal Data

Name Currently on Account (please print): ______________________________

REQUIRED Account Number **OR** Last 4 of SSN: ______________

Previous Address Information

Street Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Home Phone: ______________ Work Phone: ______________ Date of Birth: ______________

Employer Name: ______________________________

New Address Information

Street Address: ______________________________

City: ______________________ State: __________ ZIP: __________

Home Phone: ______________ Date of Birth: ______________

Email: ______________________________

Name Change

You must include a copy of your driver's license, social security card, or legal document as proof of name change.

New Name (please print): ______________________________

Authorization

Your signature is required to process this form. **Please note: If you are currently receiving a distribution, your next distribution may be delayed until the change of address is effective.**

Signature: ______________________________ **Date:** __________

Form Return

Mail: New York State Deferred Compensation Plan
Administrative Service Agency
PO Box 182797
Columbus, OH 43218-2797

Overnight Mail: New York State Deferred Compensation Plan
Administrative Service Agency, 1-LC-F2
1 Nationwide Plaza
Columbus, Ohio 43215-2239

Fax: 1-877-677-4329

When faxing paperwork, please allow two hours for your form to be received. If your fax is sent after 3:00pm your paperwork will be filed on the next business day.