New York State
Deferred Compensation Plan
*A Plan for Your Future*

# New York State Deferred Compensation Plan
## Public Safety Officer Insurance Premium Payment Authorization Form



**Helpline:** 800-422-8463 • nysdcp.com

## Personal Data

Name (please print): _____

**REQUIRED** Account Number **OR** Last 4 of SSN: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Primary Phone Type: ☐ Cell ☐ Work ☐ Home

Email: _____

How would you like to be contacted if additional information is required? ☐ Phone ☐ Email

☐ **Alerts (Optional)** – Please send me alerts regarding this distribution via: ☐ Email **OR** ☐ SMS to my cell number*

* By selecting this option, you are opting into receiving text messages from the Plan administrator. Message and data rates may apply.

## Payment Method

**Pursuant to the enclosed Health and/or Long -Term Care Insurance premium notice, I hereby authorize the transfer of $_____ to the insurance carrier listed below.** (I understand that a copy of the insurance premium notice must be included with this form and that this request will be delayed if I do not include a copy of the premium notice.)

**Premium Due Date_____ (We must receive this form and a copy of the insurance premium notice no later than 15 days prior to the premium due date.)**

**Payment Frequency (select one):** ☐ One Time ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Insurance Carrier: _____

Mailing Address: _____

City, State, and Zip Code: _____

**Federal Tax**-The Plan does not withhold Federal Income tax when processing this distribution; however, the distribution will be reported as ordinary income on the tax form 1099r. The Plan cannot offer tax guidance. Please consult with your tax advisor on how to report this as a Federal exemption that may be available to you. ***Important*** **State Taxes**-Your state of residence may have differing tax requirements from the federal exemption. If your state mandates that state taxes be withheld at the time of processing this distribution that will be reflected in the net amount of the distribution check **which in turn may result in less than the amount owed being sent to your insurance carrier.**

☐ I wish to cancel the systematic public safety officer distribution currently processing on my New York State Deferred Compensation Plan account.

## Authorization

I hereby authorize the Plan's trustee to pay the Health and Long Term Care Insurance premiums directly to my insurance carrier. I understand that these benefits will be paid directly to the carrier (subject to a $3,000 per year limitation) and will not be made to me. I certify that I am a qualified public safety officer who has retired from employment as a police officer, firefighter, correction officer, parole officer, probation officer, or a member of a rescue squad or ambulance crew because I attained retirement age or due to disability.

I understand that funds will be withdrawn pro-rata from my Plan account to pay this premium. I understand that some mutual funds may impose a short-term trade fee and that I should read the underlying prospectuses carefully.

I understand the Plan must verify my termination date prior to processing my request. I understand that I may be subject to civil and criminal liability for any false statements on this form or any papers attached to or related to this form or my claim under the Plan.

**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.