New York State Deferred Compensation Plan

Alternate Payee Benefit Distribution

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.

Distribution Method

Eligibility to Withdrawal funds (Select one that applies.) Please Note: If one of the following eligibility reasons does not apply, you are not eligible to distribute funds from **you** Alternate Payee account at this time.

☐ My Alternate payee account was established within the past 60 business days.

☐ My Alternate payee account was established more than 60 business days; **however, the original participant either has attained age 50 or older or is retired/separated from service.**

Distribution Setup

☐ **Full Distribution:** If you are electing a Full Distribution of your Plan account, please check the box. Please proceed to the Payment Method section.

☐ **Partial Distribution:** Amount: $__________ Effective Upon Receipt. This can be done in combination with Periodic Payments.

☐ **Periodic Payments:** Please select one option only.

a. Fixed Dollar Amount of $ ____________________ **OR** Fixed Time Period of __________ years

b. Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

c. Start Date: ____________________ (mm/dd/yyyy) *If a start date is not provided, the distribution start date will be the date your request is processed and therefore all subsequent distributions will process on the same date.*

NOTE: If you are age 73 or older, you may be required to receive a Required Minimum Distribution (RMD). If you selected Periodic Payments and you do not satisfy your RMD, an additional check will be sent to you to meet your RMD prior to year-end.

☐ Life Expectancy Distributions: (Recalculated annually based on life expectancy tables.)

a. Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

b. Start Date: ____________________ (mm/dd/yyyy) *If a start date is not provided, the distribution start date will be the date your request is processed and therefore all subsequent distributions will process on the same date.*

NOTE: Uniform Life and Joint and Last Survivor Life Expectancy tables are prepared by the United States Department of the Treasury. Information regarding the life expectancy of a person of your age and situation can be obtained by calling the HELPLINE at 1-800-422-8463 and speaking to a Representative or Account Executive, or you can access the table on the Plan Web site at www.nysdcp.com.

Source Type: ☐ Pre-Tax (default) ☐ Roth ☐ Rollover* ☐ Prorated across All source types

***Denotes assets rolled into the Plan from another retirement plan.**

Investment Option: ☐ Prorated from All Investments (default) ☐ Stable Income Fund only

NOTE: If the Stable Income Fund is selected but is unable to fully fund the request, the distribution will be prorated from all investments

☐ **Direct Rollover to another retirement plan. Must be the full Plan account balance.** (Please note: If you are age 73 or older and your annual Required Minimum Distribution (RMD) has not been satisfied by the time this rollover request is received, the Plan must process the RMD prior to the rollover. The IRS requires the RMD check be made payable to you. The remaining amount of your account will be sent separately as a rollover check.)

Make check payable to: ______________________________ FBO: ______________________________
(Financial Institution Name) (Your name)

NOTE: Rollovers out of the Plan are released in check form only and are always sent to the participant's address on record with the Plan. The check will be made payable to the accepting financial institution for the benefit of (FBO) the participant and can only be cashed by that financial institution. It is the participant's responsibility to forward the rollover check to the accepting financial institution it is intended for.

Payment Method

☐ **Send a check** - Default option if no other selection is made.
Allow 7 to 12 business days from the process date for receipt.

Direct Deposit ACH - A check will be issued if this ACH information cannot be validated or if the funds are returned. Allow 4 to 6 business days from the process date for receipt in your bank account.

☐ **Direct Deposit ACH on file with the Plan** - Last 4-digits of Bank Account Number on file:____________________

☐ **New Direct Deposit ACH** - send funds to my bank account using the information provided below.

Account Type/Verification needed: ☐ Checking Account **OR** ☐ Savings Account

Verification - New Direct Deposit (ACH) information provided to the Plan may require an additional verification. If that verification is needed a NYSDCP representative will contact you to resolve that on a recorded line.

Bank or Credit Union Name: ____

ABA/ Routing Number (First nine digits only): ________________________

Bank Account Number: ______________________________________

Tax Withholding

Federal Income Tax Withholding Options - The Plan will default to the standard Federal Income Tax Withholding (FIT) indicated under the Type of Payment (shown below) unless otherwise directed.

IRS Forms W-4R and W-4P - Review your type of Payment below. When required, the W-4 forms can be obtained under the Distribution tab of the Forms and Publications section on www.nysdcp.com or by calling the HELPLINE.

Type of Payment	**Standard Federal Income Tax (FIT)**	**If you want an amount more than standard.**	**Is a Federal Income Tax (FIT) amount less than 20% allowed?**
Full Withdrawal	20% FIT	Indicate a percentage on Form W-4R	No
Partial Withdrawal	20% FIT	Indicate a percentage on Form W-4R	No
Periodic Payout lasting less than 10 years.	20% FIT	Indicate a percentage on Form W-4R	No

☐ **Standard 20% FIT** ☐ **I elect more than standard FIT. I have indicated a % on IRS form W-4R.**

Type of Payment	**Standard Federal Income Tax (FIT)**	**If you want an amount different than standard but more than zero.**	**Is zero Federal Income Tax (FIT) allowed?**
Periodic Payout lasting 10 years or more	FIT is withheld using the current standard IRS withholding rule of single with zero allowances.	**Indicate a dollar amount on W-4P**	**Yes** **No additional form required. If you want zero FIT check the 'Zero FIT' box below.**

☐ **Standard single and zero** ☐ **Zero FIT** ☐ **I elect a FIT different than the standard but more than zero.**
I have indicated a dollar ($) amount on IRS form W-4P.

Type of Payment	**Standard Federal Income Tax (FIT)**	**If you want an amount different than standard but more than zero.**	**Is zero Federal Income Tax (FIT) allowed?**
Required Minimum Distribution (RMD). For those 73 or older and retired.	10% FIT	Indicate a percentage on W-4R.	**Yes** **No additional form required. If you want zero FIT check the 'Zero FIT' box below.**

☐ **Standard 10% on RMD.** 10% Federal Income Tax (FIT) will be withheld on the RMD amount but if a portion of this distribution is more than the RMD that needs to be satisfied 20% FIT will be withheld on the overage.

☐ **Zero FIT on RMD.** Zero Federal Income Tax (FIT) will be withheld on the RMD amount but if a portion of this distribution is more than the RMD that needs to be satisfied, 20% FIT will be withheld on the overage.

☐ **I elect a FIT different than the standard but more than zero.** The Federal Income Tax (FIT) indicated on form W-4R will be withheld on the amount that represents the RMD. **When an amount of 20% FIT or more is selected on W-4R** - The percentage on the W-4R will be taken on the entire distribution (the RMD and the amount over RMD.) **When a percentage more than zero but less than 20% is selected on W-4R.** The amount on the W-4R will be taken on the RMD only. The overage still will be taxed at the standard 20%. FIT.

Tax Withholding (cont.)

State Income Tax Withholding Options

REQUIRED - You must select one option below or your request will not be proessed.

(Exception: New Jersey residents must skip these options and must indicate withholding below)

If you are a resident in a state that mandates state income tax withholding be aware that any state tax amount you request below (including zero) will have the mandatory state taxes withheld in addition to your selection.

☐ I request a withholding rate of $____________________ **OR** _________% (whole dollar amount or percentage only)

☐ Please do not withhold state taxes (if there is a mandatory state tax withholding amount, it will still be withheld.)

****REQUIRED FOR NEW JERSEY RESIDENTS ONLY****
I request a New Jersey state tax withholding rate of $_________________ (whole dollar amount only)

Authorization

I understand I have a right to receive and review the Special Tax Notice Regarding Plan Payments no less than 30 days and no more than 180 days prior to this distribution. However, if I elect to receive this distribution before the end of the 30-day minimum notice period, this election shall constitute a waiver of my rights to the 30-day notice requirement.

I hereby authorize the Plan's trustee to initiate direct deposits from the Plan to the account referenced above with the financial institution named above. This authority will remain in effect until I have given the Plan written notice that I have terminated the above referenced account or until I have been notified that this deposit service has been terminated. I understand that I must give the Plan sufficient advance notice to allow for processing of these instructions. If an incorrect amount should be deposited into my account by the Plan, I authorize the Plan to direct my bank to make the appropriate credit or debit adjustment.

I understand that mutual funds may impose a short-term trade fee and that I should read the underlying prospectuses carefully for more information.

I have read the instructions and understand the requirements. 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.

⚠ **Did you know? You can easily submit your distribution request online and track the status of it!** Log into your account at www.nysdcp.com click "Manage Account" and "Withdraw Money" to start your online distribution request. Click "Track Withdrawal Status" to receive real time updates on the status of your distribution.