New York State
Deferred Compensation Plan
A Plan for Your Future

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: _____

(If your identification information above is not provided your request will be delayed)

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 withdraw funds (Select one that applies.) Please Note: If one of the following eligibility reasons do not apply, you are not eligible to distribute funds from **your** 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 website at www.nysdcp.com.

Source Type: Select the source that applies.

☐ **Pre-tax only** - The default source if none are selected.

☐ **All** - Prorated from all source types.

☐ **Roth** - If all or a part of your request will go towards satisfying a RMD, the funds in roth source will be excluded from the RMD calculation, and the RMD cannot be withdrawn from Roth funds per SECURE Act 2.0 legislation.

☐ **Rollover** - You will have this source type if money was rolled into the original participant's account in the past from another retirement plan. Selecting this DOES NOT indicate you are requesting a rollover out of the account.

Distribution Method (continued)

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 balance of the account.

Did you know? If you are required to withdraw an annual RMD and your current year's RMD has not been satisfied prior to this rollover request, the Plan must process this year's RMD and then process your rollover. **This happens whether you request a partial or full rollover.** The IRS requires that the RMD be made payable to you.

NEW FINANCIAL INSTITUTION INFORMATION

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

Note: A check will be made payable to the new financial institution for the benefit of (FBO) the participant. Please allow for regular mailing times (7 to 12 business days from the check creation date). The participant must send the rollover check to the new financial institution. The Plan cannot process "In Kind" rollovers or send rollovers via ACH or Wire.

Payment Method

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

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 of funds 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 phone call.

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.

PLEASE NOTE: Qualified Roth distributions are not subject to income tax. Unqualified Roth distributions will be taxed on the portion that represents earnings above the contributed amount. A qualified distribution is one that occurs when you are over 59.5 years of age and the account has been established for more than 5 years.

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 Form 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).	10% FIT	Indicate a percentage on Form 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 Form W-4R,** the percentage on Form 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 Form W-4R**, the amount on Form W-4R will be taken on the RMD only. The overage will still be taxed at the standard 20% FIT.

State Income Tax Withholding Options - State tax is reported to the state associated with your address of record at the time this request is processed.

Select one option that applies below:

*New Jersey residents skip to the last item in this section which references New Jersey specifically.

Please note: With either option, where applicable, the amount you select will be superseded by any mandatory state withholding requirements.

☐ I request a withholding rate of $_____ **OR** _____%
(Even dollar amounts or Whole percentage only)

☐ Please do not withhold state taxes
(Please note: If you are a resident in a state that mandates state tax withholding at the time of processing, that mandatory amount will be withheld even if you select this option.)

For New Jersey residents only

☐ I request a **NJ state tax** withholding of $_____ (Required: Whole dollar amounts only.)

Authorization

I understand that 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 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 3:00 p.m. your paperwork will be filed on the next business day.