



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: ☐ Home ☐ Cell ☐ Work

Employer: _____

State Agency Code/Local Employer/ID Number: _____

Verification of Active Military Duty

In accordance with the HEART Act, the Plan is required to have verification of active duty in the uniformed services to receive a distribution. To verify that you have been called to active duty, please provide one of the following:

Copy of Orders: Orders must specify the start and the end date. The period of active duty must be greater than 30 days.

OR

Verification from your employer: By signing below, I verify that the above-referenced employee was called to active duty and is currently on military leave.

Employer Name: _____

Agency or Employer Code: _____ Primary Phone: _____

Title of Authorized Employer Representative: _____

Signature _____ Date: _____

Military Leave Start Date: _____ Military Leave End Date: _____

Distribution Options

Please select one of the following distribution options. Also, please be aware that the payment will not be made until after the start of the military leave.

☐ Lump sum withdrawal for the entire account balance

☐ Partial lump sum in the amount of \$ _____

Payment Method

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

☐ **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 (FIT): The IRS requires the Plan to withhold a standard 20% Federal Income Tax (FIT) at the time this distribution is processed. If you want more than the standard 20% FIT withheld, please complete IRS Tax Withholding form W-4R and submit it with this form. The IRS form W-4R can be found on www.nysdcp.com under the **Distribution** tab of the **Forms and Publications** section of the website, or can be obtained by calling the HELPLINE at 1-800-422-8463.

State Income Tax Withholding (SIT): If you wish to have state tax withholding from this payment please indicate below. If state tax is not mandatory and a selection is not made below, the standard default SIT will be zero. However, if you are a resident in a state that mandates state income tax withholding at the time the funds are withheld, any state tax amount you indicate will also have the mandatory state tax.

☐ Withhold _____% of state tax withholding.

****REQUIRED FOR NEW JERSEY RESIDENTS ONLY****

I request a New Jersey state tax withholding rate of \$_____ (whole dollar amount only)

Authorization

Individuals receiving a distribution under the HEART Act are required to cease contributions to the Plan for a period of six months from the date of the first distribution. By signing below, I acknowledge that my contributions to the Plan will be stopped and are not permitted to resume for six months from the date of this distribution.

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 automatic 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 entered 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.