New York State
Deferred Compensation Plan
A Plan for Your Future

HELPLINE: 1-800-422-8463
WWW.NYSDCP.COM

AUTOMATED CLEARING HOUSE (ACH) REQUEST

Name (Please Print) ______________________ Last 4 Digits of SSN/Account Number ______________________

Employer or Former Employer ______________________ Work Telephone Number ______________________

Primary Address ______________________ Primary Telephone Number ______________________

City ____________ State ____________ Zip ____________ Date of Birth ______________________

Primary Email ______________________ ❑ Telephone ❑ Email Preferred method of contact

Name of Deceased Participant ______________________ Participant's Social Security Number ______________________

*Check all that apply**

❑ Direct Deposit (Deferred Compensation Plan distributions will be directly deposited to the account information below)

❑ Loan Repayment (Deferred Compensation Plan loan payments will be debited from the account information below)

***Please note: ACH information will be updated based upon the box(es) selected above. If no selection is made, all applicable ACH information will be updated.**

Account Type: **(Select only one option** ❑ Checking Account ❑ Savings Account

Account Verification- C*hecking Accounts*: Please provide a voided check. ***Savings Accounts*:** Please provide a letter from the bank, signed by a bank representative, which indicates the ABA/Routing Number, bank account number and the account holder's name. **We cannot accept** a deposit slip or starter check.

Bank or Credit Union Name ______________________

ABA/Routing Number: (First nine digits only) I: /___/___/___/___/___/___/___/___/___/

Bank Account Number ______________________

NOTE: Direct Deposit is only offered through members of the Automatic Clearing House (ACH).

Your bank transaction may reflect this debit generated from "Nationwide"; the recordkeeper for the NYSDCP.

A *check will be issued if this ACH information cannot be validated or if the funds are returned to us by your bank.*

I hereby authorize the Plan's trustee to initiate such automatic deposits from the Plan or a debit for Plan loan payments in accordance with the Repayment Schedule set forth in my Loan Agreement 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. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

Signature ______________________ Date ______________________

Return to: New York State Deferred Compensation Plan
Administrative Services Agency
P.O. Box 182797
Columbus, OH 43218-2797

OR Fax to: 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.

Overnight Address: New York State Deferred Compensation Plan
Administrative Service Agency, DSPF-F2
3400 Southpark Place, Suite A
Grove City, OH 43123-4856