New York State Deferred Compensation Plan
A Plan for Your Future

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

ALTERNATE PAYEE BENEFIT DISTRIBUTION

PERSONAL DATA

Name (Please Print) _____

Required: Account # (preferred) OR Last 4 of SSN _____

Primary Address _____

Date of Birth _____

City _____ State _____ Zip _____

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

Primary Email _____

How would you like to be contacted if additional information is required to process your request? ❑ Phone ❑ Email

❑ **This is a change to my home address of record. Please update my account accordingly**

❑ **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 <u>one</u> 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.**

<u>Distribution Setup</u>

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

❑ **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 72 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.

❑ **Direct Rollover:** Must be Full Plan Account Balance. *<u>Please proceed to Transfer Section</u>*

Please note: If an RMD is required, any unsatisfied RMD will be distributed prior to the rollover and will be payable to you.

For Partial, Periodic, or Life Expectancy Distributions, please complete the items below:

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

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

Please note: Amounts withdrawn from Roth or Rollover sources may require an additional 10% withholding; which will only be applied if instructed on page 2.

Investment Option: ❑ Prorated from All Investments (default), ❑ Stable Income Fund *only,*

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

PAYMENT METHOD

☐ **Send a check** - Default option if no other selection is made. Allow 5 to 10 business days from process date for delivery.

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 *(select one)***:**
☐ Checking Account - Please provide a voided check. **We cannot accept a deposit slip or starter check.**
☐ Savings Account - Please provide a letter from the bank, signed by a bank representative, containing the account detail below.

Bank or Credit Union Name: _____

ABA/Routing Number (First nine digits only): _____ Bank Account Number: _____

Is this account associated with a brokerage firm or other investment firm? ☐ Yes ☐ No
If yes, have you confirmed that the ABA and account numbers are correct? ☐ Yes ☐ No

TAX WITHHOLDING

Federal Income Tax (FIT) Withholding Options:

For Full Distributions, Partial Distributions, or Periodic Payments of less than 10 years.
The IRS **requires** the Plan to withhold 20% of the distribution. Please indicate your tax withholding request below:

☐ Required withholding 20% (Default) ☐ Other: _____% (Cannot be less than 20%)

☐ For those 72+ RMD*: _____%

*I want this percentage FIT withheld from the RMD amount. Any portion of this withdrawal exceeding this RMD amount will be taxed at 20% FIT minimum.

For Periodic Payments of 10 years or longer, or amounts that will satisfy a Required Minimum Distribution.
The IRS **does not require** a specific withholding rate. Please indicate your tax withholding request below:

☐ Standard withholding 10% (Default) ☐ Other: _____% (any whole percentage)

☐ Please do not withhold federal taxes

State Income Tax Withholding Options: REQUIRED - You must select one option below or your request will not be processed.

(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)

❑ **Transfer Assets to another Eligible Retirement Account**
(This option is only available to the former spouse of a participant.)

_____
Name of Employer or Sponsor

_____
Make check payable to

_____
For the benefit of
(Note: The check will be sent to the Alternate Payee Address on record with Administrative Service Agency)

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 such 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

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

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

OR Fax to: 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.