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

CORONAVIRUS-RELATED DISTRIBUTION ROLLOVER FORM

PERSONAL DATA

Name (Please Print) ______________________ Account Number (preferred) or Last 4 of SSN ______________________

Primary Address ______________________ Date of Birth ______________________

City ______________________ State __________ ZIP __________ Home Phone ______________________

Employer ______________________ Work Phone ______________________

State Agency Code/Local Employer/ID Number ______________________

INVESTMENT DIRECTION

Amount of Repayment: $______________________

- **Amount cannot exceed the Original Full Amount of Distribution listed above (up to $100,000)**
- **Amount cannot include any ROTH funds; These amounts would need to be repaid to a ROTH IRA**

Please allocate my repayment (select one):

☐ According to the current allocation on file **OR** ☐ As listed below (must total 100%)

Please note: If no selection is made or you do not indicate Investment Options, your repayment will be credited to your current allocation on file. Additionally, if you select an investment option that is closed, your repayment will be credited to the NYSDCP Stable Income Fund.

Investment Option	Percent
______________________	______%
______________________	______%
______________________	______%

SELF-CERTIFICATION AND AUTHORIZATION

By signing this form, I certify that I meet at least one of the qualifications for a distribution as defined under the CARES Act Section 2202(a)(4)(A) summarized below:

1. I have been diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention (including a test authorized under the Federal Food, Drug, and Cosmetic Act); or
2. My spouse or my dependent have been diagnosed with such virus or disease by such a test; or
3. I, my spouse, or a member of my household (someone who shares my principal residence) have experienced adverse financial consequences stemming from such virus or disease as a result of:
   i. Being quarantined, furloughed or laid off, or having work hours reduced; or
   ii. Being unable to work due to lack of child care; or
   iii. The closing or reduction of hours of a business I/we own or operate; or
   iv. Having pay (or self-employment income) reduced, having a job offer rescinded or start date for a job delayed.

By signing below, I certify my repayment is from a Coronavirus-Related Distribution (CRD) and does not exceed the total amount taken for this type of request. I understand that my repayment will become subject to the terms and conditions of the plan. I certify that I satisfy the requirements for making this repayment and this represents an amount which is eligible for repayment. I expressly assume responsibility for the eligibility of this repayment and any tax consequences relating to this repayment and I agree NYSDCP will not be responsible for those tax consequences.

These repayments must be made within 3 years of receipt of a Coronavirus-Related Distribution.

Participant Signature: ____ **Date:** ______________________

FORM RETURN

Send Regular and Overnight Mail to:
New York State Deferred Compensation Plan
385 Jordan Rd.
Troy, NY 12180

Fax:
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 remember to:
- Complete the Personal Data section?
- Answer all the questions on the form?
- Sign and date the form?
- Include all pages in the return envelope?