New York State Deferred Compensation Plan
A Plan for Your Future

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

IN-SERVICE DISTRIBUTION OF ROLLOVER ACCOUNT

PLEASE NOTE: Complete this form only if you are under age 59.5 and have rollover source funds.

PERSONAL DATA

Name (Please Print)

Required: Account Number (Preferred)
OR last 4 of SSN

Primary Address

Date of Birth

City State Zip

Primary Telephone Number
❑Telephone ❑Email
Preferred method of contact

Primary Email

ROLLOVER INFORMATION

If you have made rollover contributions to the Plan from more than one qualified retirement plan, please indicate from which rollover contribution the requested distribution is to be made.

Check Plan Type: ❑ 457(b) ❑ Qualified Plan ❑ IRA

Previous Plan Administrator

Current Approximate Account Value

DISTRIBUTION METHOD

Distribution Setup

❑ **Full Distribution:** If you are electing a Full Distribution of your Plan Rollover account, please check the box. *Please proceed to the Tax Withholding 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. Process Date: _____/_____/_____ (mm/dd/yyyy) *If a start date is not provided, the distribution start date will begin on the date your request is processed and therefore all subsequent distributions will process on the same date.*

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

Transfer my Rollover Account to another Qualified Retirement Account.

❑ Full Rollover Balance
❑ Partial Rollover Balance. $_____

Name of Employer or Sponsor

Make check payable to: _____
Financial Institution Name

For Benefit of: _____
Participant's Name

NOTE: Rollovers out of the Plan are released in check form only and are always sent to the participant's address on record with the Plan. The check will be made payable to the accepting financial institution for the benefit of (FBO) the participant and can only be cashed by that financial institution. It is the participant's responsibility to forward the rollover check to the accepting financial institution it is intended for.

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

Please indicate your choice of Federal or State Income Tax Withholding

Federal Withholding:

❑ **For amounts that are a Full Distribution, Partial Distribution, or Periodic Payments of less than 10 years. The IRS requires the Plan to withhold 20%** of the distribution. If you want the Plan to withhold an amount other than the required 20% please indicate below:

❑ _____% Other (More than 20%)

❑ **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:

❑ Default withholding 10%

❑ _____% Other (any whole percentage, can be 0%)

❑ Please do not withhold taxes

State Withholding: *REQUIRED SELECTION.* You must select one option below or your request will not be processable. Please note: With either option where applicable the amount you select will be superseded by any mandatory state withholding requirements.
Select only **one option** that applies: **(Exception: New Jersey residents must skip this and proceed to next item below)**

❑ I request a withholding rate of $_____OR_____% **(Whole percentage or Even dollar amounts only)**

❑ Please do not withhold state taxes at this time**. (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 $_____ (Whole dollar amount required)

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 attest that the information provided on this form is true and that I have received and read the Special Tax notification that the Federal law requires not more than 180 days prior to requesting this distribution. I have read the instructions and understand the requirements. I understand that I may be subject to civil and criminal liability for any false statement on this form or any papers attached to or related to this form or my claim under the Plan.
I understand that the distributions of assets that were rolled in to the Plan from another qualified retirement plan or an IRA may be subject to an early distribution tax, unless an exemption applies.

If I have elected to have my distributions from the Plan be directly deposited, I hereby authorize the Plan's trustee to initiate such 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 understand that mutual funds may impose a short-term trade fee and that I should read the underlying prospectuses carefully for more information.

_____ _____

Participant 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.