New York State
Deferred Compensation Plan
A Plan for Your Future

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

SMALL INACTIVE ACCOUNT WITHDRAWAL

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.

INSTRUCTIONS

By signing this application, I hereby acknowledge that the following criteria have been met:

1. My New York State Deferred Compensation Plan account balance does not exceed $5,000.00 including the unpaid balance of a Plan loan, but excluding rollover contributions, as of the date of this one time Small Inactive Account Withdrawal election.
2. There have been no contributions to the Plan during the two-year period ending on the date of this Small Inactive Account Withdrawal distribution election.
3. There has been **NO** prior Small Inactive Account Withdrawal distribution under the Plan. (This is a one-time only option.)
4. I am currently employed by the State of New York or a participating employer.
5. I understand that the Plan will withhold a 20% mandatory Federal Tax Withholding to comply with IRS guidelines.

Amount of assets to be withdrawn:

❑ $_____ (not to exceed $5,000), or ❑ Total account balance (not to exceed $5,000)

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 INFORMATION

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 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)
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. I understand that I may be subject to civil and criminal liability for any false statement on this form. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

_____ _____
Participant Signature Date

Return to: New York State Deferred Compensation Plan
Administrative Service Agency
P.O. Box 182797
Columbus, OH 43218-2797
OR Fax to: 1-877-677-4329

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

When faxing paperwork, please allow two hours from receipt for it to be processed.
If your fax is sent after 3 p.m. your paperwork will be processed on the next business day.