New York State
Deferred Compensation Plan
A Plan for Your Future

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

TAX WITHHOLDING CHANGE REQUEST

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**

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*: _____% (Cannot be less than 20%)

*A portion of this request represents my RMD. I want this percentage FIT withheld from **the entire gross amount**, including RMD. If selected but left blank, default amounts of 10% FIT on the RMD and 20% FIT on the overage will be withheld.

☐ **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)

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 understand that the execution of this form and delivery thereof to the New York State Deferred Compensation Plan revokes any prior income tax withholding instructions I have made.

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 for your form to be received.
If your fax is sent after 3:00pm your paperwork will be filed on the next business day.