New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan
Automatic Clearing House (ACH) Request

Helpline: 800-422-8463 • nysdcp.com

Personal Data

Name (please print): _____

REQUIRED Account Number **OR** Last 4 of SSN: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Preferred method of contact: ☐ Phone ☐ Email

Beneficiary Data (If Applicable)

Name of Deceased Participant: _____ Participant's SSN: _____

Instructions

*Check all that apply**

☐ **Direct Deposit** (Deferred Compensation Plan distributions will be directly deposited to the account information below)
Allow 4 to 6 business days from the process date for receipt in your bank account.

☐ **Loan Repayment** (Deferred Compensation Plan loan payments will be debited from the account information below)

***Please note: ACH information will be updated based upon the box(es) selected above. If no selection is made, all applicable ACH information will be updated.**

Account Type/Verification needed

☐ Checking Account **OR** ☐ Savings Account

Verification: New Direct Deposit (ACH) information provided to the plan may require an additional verification. If that verification is needed a NYSDCP representative will contact you to resolve that on a recorded line.

Bank or Credit Union Name: _____

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

NOTE: Direct Deposit is only offered through members of the Automatic Clearing House (ACH).
Your bank transaction may reflect this debit generated from "Nationwide"; the recordkeeper for the NYSDCP.
A check will be issued if this ACH information cannot be validated or if the funds are returned to us by your bank.

Authorization

I hereby authorize the Plan's trustee to initiate such automatic deposits from the Plan or a debit for Plan loan payments in accordance with the Repayment Schedule set forth in my Loan Agreement 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. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

Signature: _____ **Date:** _____

Form Return

Mail: New York State Deferred Compensation Plan
Administrative Service Agency
PO Box 182797
Columbus, OH 43218-2797

Overnight Mail: New York State Deferred Compensation Plan
Administrative Service Agency, 1-LC-F2
1 Nationwide Plaza
Columbus, Ohio 43215-2239

Fax: 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.