New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan
Small Inactive Account Withdrawal

Helpline: 800-422-8463

Personal Data

Name (please print): _____

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

Street Address: _____

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? ☐ Phone ☐ Email

☐ **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. Per IRS guidelines, I understand the Plan is required to withdraw the standard 20% Federal Income Tax (FIT). If I want more than the standard 20% FIT, I must indicate that on IRS Withholding form W-4R and submit it with this form.
6. You must select an option for your State Income Tax (SIT). You can request a specific dollar and/or percentage or you can request no SIT withholdings. If you are a resident in a state that mandates state income tax withholding, be aware that any state tax amount you request (including zero) will have the mandatory state taxes withheld in addition to your selection.

Amount of assets to be withdrawn: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 7 to 12 business days from the process date to receive the check.

Direct Deposit ACH - A check will be issued if this ACH information cannot be validated or if the funds are returned. Allow 4 to 6 business days from the process date for receipt of funds in your bank account.

☐ **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: ☐ 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 phone call.

Bank or Credit Union Name: _____

ABA/ Routing Number (First nine digits only): _____

Bank Account Number: _____

Tax Information

Federal Income Tax (FIT)

Per IRS guidelines, the Plan is required to withdraw the standard 20% Federal Income Tax (FIT) on this request. A FIT amount less than 20% FIT cannot be requested. However, if you want to request more than the standard 20% FIT, you must indicate that percentage on IRS Withholding form W-4R and submit it with this form. The **IRS W-4R** form can be found on www.nysdcp.com under the **Distributions** tab of the **Forms and Publications** section of the website or by calling the HELPLINE at 1-800-422-8463.

☐ Withhold the required, standard 20% Federal Income Tax.

☐ Withhold **more than the standard 20%** Federal Income Tax. **I have indicated my Federal Income Tax percentage on the IRS withholding form W-4R I am submitting it with this form.**

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

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.

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 3:00 p.m. your paperwork will be filed on the next business day.