New York State Deferred Compensation Plan
A Plan for Your Future

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

ALTERNATE PAYEE BENEFIT DISTRIBUTION

PERSONAL DATA

Name (Please Print) _____ Account Number (Preferred) OR Last 4 of SSN _____

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

❑ **This is a change to my home address of record. Please update my account accordingly.**

DISTRIBUTION METHOD

❑ **I am not required to receive a benefit payment at this time and I wish to defer payments until further notice. The distribution of funds will be deferred until the participant, from whose account the funds were transferred, separates from service or attains age 50, whichever comes first.**

Distribution Setup

❑ **Full Distribution:** If you are electing a Full Distribution of your Plan account, please check the box. It will be sent as a check and is not eligible for direct deposit. *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. Start Date: _____/_____/_____ (mm/dd/yyyy) *If a start date is not provided, the distribution start date will be the date your request is processed and therefore all subsequent distributions will process on the same date.*

Note: If you are age 70½ or older, you may be required to receive a Required Minimum Distribution (RMD). If you selected Periodic Payments and you do not satisfy your RMD, an additional check will be sent to you to meet your RMD prior to year-end.

❑ **Life Expectancy Distributions:**

a. Frequency: ❑Monthly ❑Quarterly ❑Semi-annually ❑Annually
b. Start Date: _____/_____/_____ (mm/dd/yyyy) *If a start date is not provided, the distribution start date will be the date your request is processed and therefore all subsequent distributions will process on the same date.*

Note: Uniform Life and Joint and Last Survivor Life Expectancy tables are prepared by the United States Department of the Treasury. Information regarding the life expectancy of a person of your age and situation can be obtained by calling the HELPLINE at 1-800-422-8463 and speaking to a Representative or Account Executive, or you can access the table on the Plan Web site at www.nysdcp.com.

❑ **Direct Rollover:** Must be Full Plan Account Balance. *Please proceed to Transfer Section*

For Partial, Periodic, or Life Expectancy Distributions, please complete the items below:

Source Type: ❑ Pre-Tax (default),❑ Roth, ❑ Rollover*, ❑ Prorated across All source types.

***Denotes assets rolled into the Plan from another retirement plan.**

Please note: Amounts withdrawn from Roth or Rollover sources may require an additional 10% withholding; which will only be applied if instructed on page 2.

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

Direct Deposit (Not available for a Full Account Distribution)

STAPLE VOIDED CHECK HERE

Check only one option: ❑Checking Account ❑Savings Account

*** Please note: You must include verification from your bank confirming your account number and ABA number (ex: voided check for checking account or letter from bank confirming savings account and ABA number).**

_____ _____

Bank/Credit Union Name Account Number

ABA NUMBER (First nine digits only) I: /____/____/____/____/____/____/____/____/____/ I:

Your ABA number appears at the bottom of your checks between the markings indicated above.

Bank or Credit Union Telephone Number: (_____)_____

Note: Direct Deposit is only offered through members of the Automatic Clearing House (ACH).

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: State taxes will be automatically withheld *if* you are a resident in a state that mandates state income tax withholding. If you want a portion of your distribution withheld for state income taxes, please complete the following:

❑ I request a withholding rate of $_____OR_____%

Please Note: The amount provided ***may*** need to be converted from $ or % to comply with your State's requirements. 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

❑ **Transfer Assets to another Eligible Retirement Account**

(This option is only available to the former spouse of a participant.)

_____

Name of Employer or Sponsor

_____

Make check payable to

_____

For the benefit of

(Note: The check will be sent to the Alternate Payee Address on record with Administrative Service Agency)

I acknowledge that the individual named on this form is (a) an employee of the Employer named above, or (b) the owner of a traditional IRA, Roth IRA, or a conduit IRA at this institution. We sponsor a plan eligible under Internal Revenue Code 457(b), 401(a), 401(k), 403(b) or an Individual Retirement Account and the plan (sponsor) receives plan-to-plan transfers. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

_____

Signature of Authorized Personnel of Accepting Financial Organization

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 hereby authorize the Plan's trustee to initiate such direct 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 deposited 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.

I have read the instructions and understand the requirements. I understand that I may be subject to civil and criminal liability for any false statements on this form or any papers attached to or related to this form or my claim under the Plan.

_____ _____

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.