New York State
Deferred Compensation Plan
A Plan for Your Future

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

CORONAVIRUS-RELATED DISTRIBUTION FORM

PERSONAL DATA

Name (Please Print) ____________________

Account Number (preferred) or Last 4 of SSN ____________________

Primary Address ____________________

Date of Birth ____________________

City ____________________ State ________ ZIP ________

Home Phone ____________________

Employer ____________________

Work Phone ____________________

State Agency Code/Local Employer/ID Number ____________________

DISTRIBUTION OPTIONS

Please select one of the following distribution options.

☐ Lump sum withdrawal for the entire account balance

☐ Partial lump sum in the amount of $____________________
Please note: An amount must be provided and cannot exceed the lesser of 100% of the account balance or $100,000 total across all plans maintained by the Employer.

Source Type *(select all that apply)*: ☐ Pre-Tax (default) ☐ Roth ☐ Rollover* ☐ Prorated across All source types.
*Denotes assets rolled into the Plan from another retirement plan.

Investment Option *(select one)*: ☐ 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

Payment Method *(select one)*: ☐ Send a check (default) ☐ Direct Deposit ACH (complete the next section)

DIRECT DEPOSIT INSTRUCTIONS (IF APPLICABLE)

STAPLE VOIDED CHECK HERE

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

☐ **Direct Deposit ACH on file** - send funds to my **bank account** on file with the Plan.
Last 4-digits of Account Number: ____________ (required - if not provided, a check for the funds will be mailed)

☐ **New Direct Deposit ACH** - send funds to my **bank account** provided below.

Account Type *(select one)*: ☐ Checking Account ☐ Savings Account

Bank/Credit Union Name ____________________

Bank or Credit Union Phone ____________________

Account Number ____________________

|: ____________________ |:
ABA Number (First nine digits only)
(appears at the bottom of your checks between the markings indicated above)

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

Federal Income Tax Withholding: A 10% income tax will be withheld unless you elect otherwise below.

☐ No withholding ☐ Other withholding rate: ________%

State Income Tax 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:

☐ Withholding rate of: ________%

Participant Coronavirus Certification and Distribution Authorization

By signing this form, I certify that I meet at least one of the qualifications for a distribution as defined under the CARES Act Section 2202(a)(4)(A) summarized below:

1. I have been diagnosed with the virus SARS-CoV-2 or with coronavirus disease 2019 (COVID-19) by a test approved by the Centers for Disease Control and Prevention; or
2. I have a spouse or dependents diagnosed with such virus or disease by such a test; or
3. I have experienced adverse financial consequences stemming from such virus or disease as a result of:
   - Being quarantined, furloughed or laid off
   - Having reduced work hours
   - Being unable to work due to lack of child care
   - The closing or reduction of hours of a business I own or operate

Any state or federal income taxes withheld will be reported on a form 1099-R.

I consent to a distribution as elected above. I understand that the terms of the plan document will control the amount and timing of any payment from the plan.

This distribution is only to be made to a qualifying individual described above. It is important to understand that distributions will impact your taxes and your future retirement security. You should consult your tax and financial advisors on these matters including your options to roll funds back into this or another retirement plan.

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.

____ ____________________

Participant Signature **Date**

NOTE: The full text of the CARES Act can be found at https://www.congress.gov/bill/116th-congress/house-bill/748/text

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, DSPF-F2
3400 Southpark Place, Suite A
Grove City, OH 43123-4856

Fax:
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.

Did you remember to:
- Select a payment method?
- Provide all information for direct deposit or include a voided check?
- Sign and date the form?
- Include all pages in the return envelope?