New York State Deferred Compensation Plan
A Plan for Your Future

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

IN-SERVICE DISTRIBUTION OF ROLLOVER ACCOUNT

PERSONAL DATA

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

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

ROLLOVER INFORMATION

If you have made rollover contributions to the Plan from more than one qualified retirement plan, please indicate from which rollover contribution the requested distribution is to be made.

Check Plan Type: ❑ 457(b) ❑ Qualified Plan ❑ IRA

Previous Plan Administrator _____

Current Approximate Account Value _____

DISTRIBUTION METHOD

Distribution Setup

❑ **Full Distribution:** If you are electing a Full Distribution of your Plan Rollover account, please check the box. This 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.

For Partial, Periodic, or Life Expectancy Distributions, please complete the items below:
❑Transfer my Rollover Account to another Qualified Retirement Account.

_____
Name of Employer or Sponsor

Make check payable to: _____
Financial Institution

For Benefit of: _____
Participant's Name

NOTE: A rollover institution representative must sign or provide a general letter of acceptance or your transaction will be delayed.
Check will be sent to the Participant address on record.
I acknowledge that the individual named above is (a) an employee of the Employer named, or (b) the owner of a traditional 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.

_____ _____

Name of Authorized Personnel | Signature of Authorized Personnel of Accepting Financial Organization

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

STAPLE VOIDED CHECK HERE

Direct Deposit Instructions (Not available for a Full Account Distribution)

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

AUTHORIZATION

I attest that the information provided on this form is true and that I have received and read the Special Tax notification that the Federal law requires not more than 180 days prior to requesting this distribution. I have read the instructions and understand the requirements. I understand that I may be subject to civil and criminal liability for any false statement on this form or any papers attached to or related to this form or my claim under the Plan.
I understand that the distributions of assets that were rolled in to the Plan from another qualified retirement plan or an IRA may be subject to an early distribution tax, unless an exemption applies.

If I have elected to have my distributions from the Plan be directly deposited, I hereby authorize the Plan's trustee to initiate such automatic 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 entered 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.

_____ _____

Participant 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.