New York State
Deferred Compensation Plan
A Plan for Your Future

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

DIRECT DEPOSIT REQUEST

PERSONAL DATA

Name (Please Print) _____ Last 4 Digits of SSN/Account Number _____

If you are a Beneficiary: _____ _____
Name of Deceased Participant *Participant's Social Security Number*

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

Employer or Former Employer _____ Work Telephone Number _____

INSTRUCTIONS

I request that my Deferred Compensation Plan distributions be directly deposited to the following account:

*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)

STAPLE VOIDED CHECK HERE

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

AUTHORIZATION

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. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

Signature _____ Date _____

Return to: New York State Deferred Compensation Plan
Administrative Services 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 from receipt for it to be processed.
If your fax is sent after 3 p.m. your paperwork will be processed on the next business day.

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