New York State
Deferred Compensation Plan
A Plan for Your Future

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

INTERNAL PLAN-TO-PLAN

PERSONAL DATA

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

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

FORMER EMPLOYER PLAN INFORMATION

Separation from service date: _____/_____/_____ (*Internal Use – Confirmation of Termination:* _____)

Former Employer Name _____ State Agency Code/Local Employer ID Number* _____

CURRENT EMPLOYER INFORMATION

Please note: An enrollment application must be submitted for your current employer before deferrals will begin.

New Hire Date: _____/_____/_____

Current Employer Name _____ State Agency Code/ Local Employer ID Number* _____

Current Work Phone Number _____

**If you are unaware of this number, contact your payroll center or the HELPLINE.*

AUTHORIZATION

I understand that the assets transferred from my prior account with the New York Sate Deferred Compensation Plan pursuant to this application will be invested in the same manner as they were invested in my prior account. If my existing account has an active loan, I understand that it must be either paid in full or become a deemed distribution prior to the consolidation of the two accounts. Please note that if you have a Required Minimum Distribution for the current year that has not yet been satisfied, the Plan will distribute the required amount prior to the processing of your Internal Plan to Plan transfer.

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

Please select one of the options listed below:

❒ Transfer of Assets: By electing this option and combining these two accounts, I must wait until I separate from service with my current employer before I am entitled to take distributions.

OR

❒ Rollover of Assets: By electing to segregate the assets as a rollover, I understand that I will have access to them for a distribution without separating from service with my current employer. Any request for funds will be a taxable event in the year that the request was made.

Participant Signature _____ Date _____

Return to: New York State Deferred Compensation Plan
Administrative Service Agency
P.O. Box 182797
Columbus, OH 43218-2797
OR Fax to: 1-877-677-4329

Overnight Address: New York State Deferred Compensation Plan
Administrative Service Agency, DSPF-F2
3400 Southpark Place, Suite A
Grove City, OH 43123-4856

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.