New York State
Deferred Compensation Plan
A Plan for Your Future

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

REQUIRED MINIMUM DISTRIBUTION

Complete this form only if you intend to request the minimum withdrawal allowed

PERSONAL DATA

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

If you are a Beneficiary, Name of Participant: _______________ *Participant's Last 4 Digits of SSN* _______________

Home Address _______________________ Date of Birth _______________

City _______ State _______ Zip _______ Home Telephone Number _______________

Employer or Former Employer _______________________ Work Telephone Number _______________

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

DISTRIBUTION METHOD

<u>Step One: Type of Distribution (choose one)</u>

❑ **Required Minimum Distribution (RMD):** Based upon my life expectancy according to the Uniform Life Tables.

❑ **Required Minimum Distribution (RMD) with Joint Life Expectancy of Myself & Spouse:** Based upon the Joint and Last Survivor Table.
The use of the Joint and Last Survivor Life Expectancy Table is limited to participants whose spouse is MORE than ten years younger than the participant and the spouse is the sole beneficiary of record. If you have selected benefit payments based on the Joint and Last Survivor Life Expectancy Table, please complete the following:

Spouse's Name _______________ Spouse's Date of Birth _______________ Spouse's Social Security Number _______________

<u>Step Two: Distribution Setup</u> Note: If this is the first year you must satisfy your RMD, you may defer until April 1 of the following year. If you choose to defer, you will have to satisfy the RMD amounts for both years by December 31. If not otherwise selected, payments will be taken annually from the Pre-Tax portion of your account and prorated from all investments.

I elect to delay the processing of my current RMD until _________ (please provide a date prior to April first of next year and complete the following items indicating your preferences for next year's RMD)

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.*
c. Please indicate money type: ❑Pre-Tax ❑Roth ❑Rollover
d. Fund Distribution: ❑Stable Income Fund Only ❑Prorated from All Investments

<u>Step Three: Direct Deposit</u>

*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: (________)___________________

<u>Note</u>: 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

STAPLE VOIDED CHECK HERE

TAX WITHHOLDING

Federal Withholding

For Required Minimum Distributions, the IRS does not require a specific withholding rate. 10% will be withheld unless you chose a rate below:

❑ Please do not withhold taxes.

❑ I request a withholding rate other than 10%: ________% (any whole percentage)

State Withholding

The Plan is not required to withhold for state income tax purposes. If you want a portion of your distribution withheld for state income taxes, please complete the following:

❑ I request a withholding rate of __________% for the State of: __________.

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.

____ ____________________

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 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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