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) _____

Account Number (Preferred) OR Last 4 of SSN _____

If you are a Beneficiary, Name of Participant: _____

Participant's Last 4 Digits of SSN _____

Primary Address _____

Date of Birth _____

City _____ State _____ Zip _____

Primary Telephone Number _____

Primary Email _____

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

DISTRIBUTION METHOD

Step One: Type of Distribution (choose one)

❑ **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 _____

Step Two: Distribution Setup

NOTE: If this is NOT the first year you are required to take your RMD please continue to Step Three labeled "RMD Preferences".

If this **IS the first year** you are required to take your RMD please select **one option** directly below and follow the corresponding directions.

❑ It is my first year I am required to satisfy my RMD and I will **NOT** be delaying my RMD payment.
(Continue to Step Three labeled "RMD Preference")

❑ It is my first year I am required to satisfy my RMD and **I will defer my initial RMD** payment to the following year. By selecting this option, I acknowledge that I must distribute two RMD payments during the year the deferred RMD is processed; the deferred RMD payment issued prior to April 1st and the second RMD on a date of my choosing that will automatically process each calendar year. **Complete the following two required steps.**

- I elect to defer **t**he processing of my **first** RMD until ____/____/_____. *(Please provide a date prior to April 1st).*
- **Proceed to Step Three labeled "RMD Preferences" to setup your second RMD payout.** (*Subsequent RMD payouts will go out in the same manner unless modified by you at a later time.)*

Step Three: RMD Preferences

a. Process Date: _____/_____/_____ (mm/dd/yyyy). (*If a specific date is not provided we will process this RMD when it is received in good order and subsequent RMD payouts will process on that same date).*
b. Frequency: ❑Monthly ❑Quarterly ❑Semi-annually ❑*Annually (If a selection is not made we will default to annually*)
c. Source Type: ❑Pre-Tax (default)❑Roth ❑Rollover ❑Prorated across **all** source types.
d. Investment Option: ❑Prorated from **all** Investments (default) ❑Stable Income Fund Only

STAPLE VOIDED CHECK HERE

PAYMENT METHOD

❑ **Send a check.** Allow 5 to 10 business days from process date for delivery. (Default option, if no other option is selected)

Direct Deposit ACH *Please note: A check will be issued if this ACH information cannot be validated or if the funds are returned to us by your bank*

❑ **Direct Deposit ACH Instructions on File –** Send funds to my **bank account** that the Plan has on file and ends in _/_/_/_ . ***(If the last four digits of the bank account are not provided your funds will be sent out as a check).***

❑ **New Direct Deposit ACH –**(*Complete the information below)*

Account Type: **(Select only one option)** ❑ Checking Account ❑ Savings Account

Account Verification- *Checking Accounts*: Please provide a voided check. ***Savings Accounts***: Please provide a letter from the bank, signed by a bank representative, which indicates the ABA routing number, bank account number and the account holder's name. **We cannot accept** a deposit slip or starter check.

Bank or Credit Union Name _____

ABA Number/ Routing Number: (First nine digits only) I: /__/__/__/__/__/__/__/__/__/

Bank Account 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

Federal Withholding

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

❑ Please do not withhold taxes.

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

State Withholding: ***REQUIRED Selection.*** You must select **one option below or your request will not be processable.**

Please note: With either option where applicable the amount you select will be superseded by any mandatory state withholding requirements.

Select only **one option that applies: **(Exception: New Jersey residents must skip this section and proceed to next item below that references New Jersey)**

❑ I request a withholding rate of $_____OR_____%
(Whole percentage or Even dollar amounts only)

❑ Please do not withhold state taxes
(Please note: If you are a resident in a state that mandates state tax withholding at the time of processing that mandatory amount will be withheld even if you select this option)

For New Jersey residents only I request a **NJ state tax** withholding of **$**_____ (Required: Whole dollar amounts only)

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 for your form to be received.
If your fax is sent after 3:00pm your paperwork will be filed on the next business day

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