



## CHANGE OF NAME/ADDRESS

### PERSONAL DATA

Name Currently on the Account (Please print)

Social Security Number/Account Number

### PREVIOUS ADDRESS INFORMATION

Previous Home Address

Date of Birth

City

State

Zip

Previous Home Telephone Number

Employer

Work Telephone Number

### ADDRESS CHANGE

New Home Address

New Home Telephone Number

City

State

Zip

New Email Address

*\* Confirmation of your new address will be forwarded to both the previous and new addresses, for security purposes.*

### NAME CHANGE

You must include a copy of your driver's license, social security card, or legal document as proof of name change.

New Name (Please Print)

### AUTHORIZATION

Your signature is required to process this form. **Please note: If you are currently receiving a distribution, your next distribution may be delayed until the change of address is effective.**

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



**NYSDCP MAKES A DIFFERENCE!**  
**WWW.NYSDCP.COM**  
**HELPLINE: 1-800-422-8463**

*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.*

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

DC-3784-0515