



PUBLIC SAFETY OFFICER INSURANCE PREMIUM PAYMENT AUTHORIZATION FORM

PERSONAL DATA

Name (Please Print)

Account Number (Preferred)
OR Last 4 of SSN

Home Address

Date of Birth

City

State

Zip

Home Telephone Number

Telephone Email

Primary Email

Preferred method of contact

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

PAYMENT METHOD

Pursuant to the enclosed Health and/or Long Term Care Insurance premium notice, I hereby authorize the transfer of:

\$ _____ to the following insurance carrier. Premium Due Date _____

Payment Frequency (select one): One Time Monthly Quarterly Semi-Annually Annually

Insurance Carrier: _____

Mailing Address: _____

City, State, and Zip Code: _____

I wish to cancel the systematic public safety officer distribution currently processing on my New York State Deferred Compensation Plan account.

A copy of the insurance premium notice must be included with this form. Your request will be delayed if you do not include a copy of the premium notice. We must receive this form and a copy of the insurance premium notice no later than 15 days prior to the premium due date.

AUTHORIZATION

I hereby authorize the Plan's trustee to pay the Health and Long Term Care Insurance premiums directly to my insurance carrier. I understand that these benefits will be paid directly to the carrier (subject to a \$3,000 per year limitation) and will not be made to me. I certify that I am a qualified public safety officer who has retired from employment as a police officer, firefighter, correction officer, parole officer, probation officer, or a member of a rescue squad or ambulance crew because I attained retirement age or due to disability.

I understand that funds will be withdrawn pro-rata from my Plan account to pay this premium. I understand that some mutual funds may impose a short-term trade fee and that I should read the underlying prospectuses carefully.

I understand the Plan must verify my termination date prior to processing my request. 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.