New York State
Deferred Compensation Plan
A Plan for Your Future

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

SMALL INACTIVE ACCOUNT WITHDRAWAL

PERSONAL DATA

Name (Please Print) _____ Social Security Number/Account Number _____

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

Employer _____ Work Telephone Number _____

INSTRUCTIONS

By signing this application, I hereby acknowledge that the following criteria have been met:

1. My New York State Deferred Compensation Plan account balance does not exceed $5,000.00 including the unpaid balance of a Plan loan, but excluding rollover contributions, as of the date of this one time Small Inactive Account Withdrawal election.
2. There have been no contributions to the Plan during the two-year period ending on the date of this Small Inactive Account Withdrawal distribution election.
3. There has been **NO** prior Small Inactive Account Withdrawal distribution under the Plan. (This is a one-time only option.)
4. I am currently employed by the State of New York or a participating employer.
5. I understand that the Plan will withhold a 20% mandatory Federal Tax Withholding to comply with IRS guidelines.

Amount of assets to be withdrawn:

❑ $_____ (not to exceed $5,000), or ❑ Total account balance (not to exceed $5,000)

DIRECT DEPOSIT INSTRUCTIONS

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 *(A check will be issued if this ACH information cannot be validated or is rejected)*

❑ **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/ 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

I understand that the gross amount of the Unforeseeable Emergency Distribution will be calculated such that, after withholding taxes, the net amount will be as close to the amount approved as necessary to meet my financial need.

TAX INFORMATION

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. Please note the following information prior to making your state tax election. State taxes are automatically withheld if you are a resident in a state that mandates state income tax withholding at the time of withdrawal. State tax reporting related to this distribution corresponds to the state indicated on your address of record with the Plan at the time of withdrawal and is reported as ordinary income regardless of the state.

If you live in a state that does not require mandatory withholding or if you want an amount greater than is mandatory, please complete the following. Where applicable this amount 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 the 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 $_____ (Whole dollar amount required)

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 attest that the information provided on this form is true. I understand that I may be subject to civil and criminal liability for any false statement on this form. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

_____ _____

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.