New York State
Deferred Compensation Plan
A Plan for Your Future

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

TAX WITHHOLDING CHANGE REQUEST

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
Preferred method of contact

Primary Email _____

TAX WITHHOLDING

Please indicate your choice of Federal or State Income Tax Withholding

Federal Withholding:

❑ **For amounts that are a Full Distribution, Partial Distribution, or Periodic Payments of less than 10 years.**
The IRS requires the Plan to withhold 20% of the distribution. Please indicate your tax withholding request below:

- ❑ Mandatory 20%
- ❑ _____% Other (More than 20%)

❑ **For Periodic Payments of 10 years or longer, or amounts that will satisfy a Required Minimum Distribution.**
The IRS **does not** require a specific withholding rate. Please indicate your tax withholding request below:

- ❑ Default withholding 10%
- ❑ _____% Other (any whole percentage, can be 0%)

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Please note: With either option where applicable the amount you select will be superseded by any mandatory state withholding requirements.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 understand that the execution of this form and delivery thereof to the New York State Deferred Compensation Plan revokes any prior income tax withholding instructions I have made.

_____ _____
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

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.

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