New York State Deferred Compensation Plan
A Plan for Your Future

HEART ACT DISTRIBUTION FORM

PERSONAL DATA

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

Home Address _____ Date of Birth _____

City _____ State _____ Zip Code _____ Home Telephone Number _____

Employer _____ Work Telephone Number _____

State Agency Code/Local Employer/ID Number _____

VERIFICATION OF ACTIVE MILITARY DUTY

In accordance with the HEART Act, the Plan is required to have verification of active duty in the uniformed services to receive a distribution. To verify that you have been called to active duty, please provide one of the following:

Copy of Orders. Orders must specify the start and the end date. The period of active duty must be greater than 30 days.

OR

Verification from your employer. By signing below, I verify that the above-referenced employee was called to active duty and is currently on military leave.

Employer Name _____ Agency or Employer Code _____

Signature of Authorized Employer Representative _____ Date _____

Title of Authorized Employer Representative _____ Phone Number _____

Military Leave Start Date _____ Military Leave End Date _____

DISTRIBUTION OPTIONS

Please select one of the following distribution options. Also, please be aware that the payment will not be made until after the start of the military leave.

❑ Lump sum withdrawal for the entire account balance

❑ Partial lump sum in the amount of $_____

DIRECT DEPOSIT INSTRUCTIONS

STAPLE VOIDED CHECK HERE

Check only one option: ❑ Checking Account ❑ Savings Account

_____ _____
Bank/Credit Union Name Account Number

ABA NUMBER (First nine digits only) I: /____/____/____/____/____/____/____/____/____/____/ I:

Your ABA number appears at the bottom of your checks between the markings indicated above.

Bank or Credit Union Telephone 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

The IRS requires the Plan to withhold 20% of the distribution for lump sum and partial lump sum payments. If you want the Plan to withhold a greater amount, please indicate that amount below.

Other – please indicate a higher percentage amount _____ % (must be a whole percentage above 20%)

AUTHORIZATION

Individuals receiving a distribution under the HEART Act are required to cease contributions to the Plan for a period of six months from the date of the first distribution. By signing below, I acknowledge that my contributions to the Plan will be stopped and are not permitted to resume for six months from the date of this distribution.

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 automatic 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 entered into my account by the Plan, I authorize the Plan to direct my bank to make the appropriate credit or debit adjustment.

Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

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