New York State
Deferred Compensation Plan
A Plan for Your Future

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

OUTGOING ROLLOVER TRANSFER

PERSONAL DATA

Name (Please Print) _____

Account Number (Preferred) OR Last 4 of SSN _____

Home Address _____

Date of Birth _____

City _____ State _____ Zip _____

Home Telephone Number _____

TRANSFER INFORMATION

Please Select Money Type: ❑ **All** ❑ **Pretax** ❑ **Roth** ❑ **Rollover***

***Denotes assets rolled into the Plan from another retirement plan.**

If a money type is not selected, the requested amount will be taken pro-rata from all money sources.

Amount of Assets to be Transferred:

❑ Transfer my full Plan Account balance
❑ Transfer part of my Plan Account balance: $_____
❑ Other – Please attach written instructions

Did you know? The Plan cannot process a full rollover out if you currently have a balance in the Self- Directed Brokerage Account (SDBA) at Charles Schwab. Partial rollovers may also be impacted depending on the amount requested. **If you utilize the SDBA please facilitate a trade of the remaining assets there back into this Plan prior to sending in this form**

I have read the "Serving You Throughout Your Lifetime" brochure and understand that a complete distribution of my account cannot occur until 45 days after separation from service, which is dependent upon verification of the separation date from the employer. A complete rollover will close your account and no new contributions will be accepted once completed.

Please note that if you have a Required Minimum Distribution (RMD) amount for the current year that has not yet been satisfied, the Plan will distribute the remaining amount prior to the processing of your Outgoing Rollover transfer. The RMD will be sent separately in a check and will be taxable in the current year. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

Information From Employer or IRA Sponsor that Maintains the Plan Receiving The Transfer:
I acknowledge that I am an employee of the Employer named below, or (b) the owner of a traditional IRA, Roth IRA or a conduit IRA at this institution. They sponsor a plan eligible under Internal Revenue Code 457(b), 401(a), 401(k), 403 (b) or an Individual Retirement Account and the plan (sponsor) receives plan-to-plan transfers.

Participant Signature _____ Date _____

Name of Employer or Sponsor: _____

Make check payable to: _____

For benefit of: _____

Note: Check will be sent to the Participant address on record with the NYSDCP Administrative Service Agency

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