New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan
Required Minimum Distribution

Helpline: 800-422-8463 • nysdcp.com

Important: Complete this form only if you intend to request your Required Minimum Distribution (RMD).

Personal Data

REQUIRED Account Number **OR** Last 4 of SSN: _____ Name: _____

(If your identification information above is not provided, your request will be delayed.)

Email: _____ Primary Phone: _____

Phone Type: ☐ Home ☐ Work ☐ Cell

Optional – Send me alerts regarding this distribution via: ☐ Email ☐ SMS Text Message* to Cell number listed above.

* By selecting this option, you are opting into receiving text messages from the Plan Administrator. Message and data rates may apply.

How would you like to be contacted if additional information is required? ☐ Email ☐ Phone

Distribution Method

Step 1

TYPE OF DISTRIBUTION

(Choose One Type that best describes your situation.)

☐ **Required Minimum Distribution (RMD):** Based upon my life expectancy according to the Uniform Life Tables.

☐ **Required Minimum Distribution (RMD) with Joint Life Expectancy of Myself & Spouse:** Based upon the Joint and Last Survivor Table.

The use of the Joint and Last Survivor Life Expectancy Table is limited to participants whose spouse is MORE than ten years younger than the participant, and the spouse is the sole beneficiary of record. If you have selected benefit payments based on the Joint and Last Survivor Life Expectancy Table, please complete the following:

Spouse's Name: _____

Spouse's DOB: _____ Spouse's SSN: _____

☐ **Beneficiary Account** (*Spousal or non-spousal*) - **Required Minimum Distribution (RMD) for an established NYSDCP Beneficiary account.** The single life table will be used to calculate the RMD.

SECURE Act 2.0 updates effective January 1, 2024 allow spousal beneficiaries (only) who established their beneficiary account 1/1/24 or later, to elect to be treated as an employee participant for RMD purposes. **This election must be selected at the time the spousal beneficiary account is established, and cannot be modified after.** The following is available for those spousal beneficiaries who elect to be treated as an employee (original participant) for RMD purposes:

(a) Delay taking payments until the original participant would have attained RMD age,

(b) Use the Uniform Lifetime Table for RMD calculations

(c) If the Spousal Beneficiary dies before beginning distributions, they are treated as if they are the employee participant.

☐ **Select this box only if you have read the SECURE Act 2.0 information above and you are a spousal beneficiary who specifically elected at the time of establishing your beneficiary account to be treated as an employee participant for RMD purposes.**

Step 2

RMD SET UP

PLEASE NOTE: **If this is NOT the first year you are required to take your RMD:**
Please continue to Step 3 labeled "RMD Preferences" below.

If this IS the first year you are required to take your RMD:
Please select one option directly below and follow the corresponding directions.

☐ It is my first year I am required to satisfy my RMD and I will **NOT** be delaying my RMD payment. (Continue to Step 3 labeled "RMD Preference.")

☐ It is my first year that I am required to satisfy my RMD, and **I will defer my initial RMD** payment to the following year. By selecting this option, I acknowledge that I must distribute two RMD payments during the year the RMD is processed; the deferred RMD payment issued prior to April 1st, and the second RMD on a date of my choosing that will automatically process each calendar year. **Complete the following two required steps.**

- I elect to defer the processing of my **first** RMD until _____. (Please provide a date prior to April 1st).
- **Proceed to Step 3 labeled "RMD Preferences" to setup your second RMD payout.** (Subsequent RMD payments will distribute in the same manner unless modified by you at a later time.)

Distribution Method (continued)

Step 3

RMD PREFERENCES

a. Process Date: _____ (mm/dd/yyyy). (If a specific date is not provided, we will process this RMD when it is received in good order, and subsequent RMD payments will process on that same date).

b. Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually (If a selection is not made we will default to annually.)

c. Investment Option: ☐ Prorated from **all** Investments (default) ☐ Stable Income Fund Only

Step 4

SOURCE TYPE

Important: Make your Source Type selection only under the Account Type that best describes yours.

☐ Account Type: **I have an original Participant or Alternate Payee (QDRO) Account.**
Please note: SECURE Act 2.0 updates effective January 1, 2024 exclude Roth balances when calculating RMD for original participant and Alternate Payee accounts. In addition, these accounts cannot distribute their RMD from Roth sources.

Select Source Type: ☐ Pre-Tax (Default) ☐ Rollover ☐ All source types (Excludes Roth).

☐ Account Type: **I have an established Beneficiary Account. (Only beneficiaries may request RMD from Roth.)**

Select Source Type: ☐ Pre-Tax (Default) ☐ Rollover ☐ Roth ☐ All source types

Payment Method

☐ **Send a check** - Default option if no other selection is made.
Allow 7 to 12 business days from the process date to receive the check.

Important: Only provide the following address information if: 1) You are **not** selecting direct deposit.
And
2) You need to update the address on file.

Address _____ City _____ State _____ Zip _____

Direct Deposit ACH - A check will be issued if this ACH information cannot be validated or if the funds are returned. Allow 4 to 6 business days from the process date for receipt of funds in your bank account.

☐ **Direct Deposit ACH on file with the Plan** - Last 4-digits of Bank Account Number on file:_____

☐ **New Direct Deposit ACH** - send funds to my bank account using the information provided below.

Account Type/Verification Needed *(select one)*: ☐ Checking Account **OR** ☐ Savings Account

Verification: New Direct Deposit (ACH) information provided to the Plan may require an additional verification. If that verification is needed, a NYSDCP representative will contact you to resolve that on a recorded phone call.

Bank or Credit Union Name:_____

ABA/Routing Number (First nine digits only):_____

Bank Account Number:_____

Tax Withholding

Federal Withholding

The standard Federal Income Tax (FIT) withholding for Required Minimum Distributions is 10%. If a different selection is not made below, the Plan will default to the standard 10% FIT.

PLEASE NOTE: Qualified Roth distributions are not subject to income tax. Unqualified Roth distributions will be taxed on the portion that represents earnings above the contributed amount. A qualified distribution is one that occurs when you are over 59.5 years of age, and the account has been established for more than 5 years.

☐ Please do not withhold taxes.

☐ **I want a Federal Income Tax (FIT) withholding different than the standard 10%, but more than zero withholding. I understand this FIT percentage must be indicated on IRS Form W-4R and submitted with this form.** The **IRS Form W-4R** can be obtained under the **Distribution** tab of the **Forms and Publications** section on **www.nysdcp.com** or by contacting the **HELPLINE at 1-800-422-8463**.

Tax Withholding (continued)

State Withholding - State tax is reported to the state associated with your address of record at the time this request is processed.

Please select only one option, below that applies. *New Jersey residents skip to the last item in this section which references New Jersey specifically.

Please note: With either option, where applicable, the amount you select will be superseded by any mandatory state withholding requirements.

☐ I request a withholding rate of $_____ **OR** _____%
(Even dollar amounts or Whole percentage 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 hereby authorize the Plan's trustee to initiate such direct 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 deposited into my account by the Plan, I authorize the Plan to direct my bank to make the appropriate credit or debit adjustment.

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.

Signature: _____ **Date:** _____

Form Return

Mail: New York State Deferred Compensation Plan
Administrative Service Agency
PO Box 182797
Columbus, OH 43218-2797

Overnight Mail: New York State Deferred Compensation Plan
Administrative Service Agency, 1-LC-F2
1 Nationwide Plaza
Columbus, Ohio 43215-2239

Fax: 1-877-677-4329

When faxing paperwork, please allow two hours for your form to be received. If your fax is sent after 3:00 p.m. your paperwork will be filed on the next business day.