New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan
Public Safety Officer Insurance Premium Payment Authorization Form

Helpline: 800-422-8463 • nysdcp.com

Personal Data

Name (please print): _____

REQUIRED Account Number **OR** Last 4 of SSN: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ Primary Phone Type: ☐ Cell ☐ Work ☐ Home

Email: _____

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

☐ **Alerts (Optional)** – Please send me alerts regarding this distribution via: ☐ Email **OR** ☐ SMS to my cell number*

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

Payment Method

Select One Option that Applies.

☐ **Send the payment directly to my insurance carrier** - Make the Public Safety Officer Insurance check payable to my insurance company for my benefit (FBO) and mail it directly to them. **I have ensured the insurance carrier information below is accurate and I have included a copy of the premium notice.** (Proceed to the "Payment Details" section of this form after you provide your insurance carrier information).

Insurance Carrier: _____

Mailing Address: _____

City, State, and Zip Code: _____

☐ **Send the payment to me** - By selecting this option I understand the Public Safety Officer Insurance check will be **payable to me and will be mailed to my address of record. I also understand it is my responsibility to ensure my insurance carrier receives this payment by the due date to avoid any potential impact on my insurance status.** (Proceed to the "Payment Details" section of this form to complete your request).

☐ **Cancel my current Payment** - I have a Public Safety Officer Insurance Premium distribution currently processing from my New York State Deferred Compensation Plan (NYSDCP) account and I wish to cancel it. (After this selection is made, please proceed to the "Authorization" section of this form).

Payment Details

Pursuant to Internal Revenue Service (IRS) regulations and as a retired Public Safety Officer, I elect to have a portion of my Health and/or Long-Term Care insurance distributed from my Plan account. **I understand the IRS dictates this benefit cannot exceed the amount of $3,000 in a calendar year.**

- **Payment Amount $**_____ (**Required:** To avoid delays, a copy of your most current insurance premium notice must be included with this form.)
- **Payment Due Date** ___/___/___ (**Required:** This form and a copy of the Insurance premium notice must be received **15 days** prior to the premium due date).
- **Payment Frequency** (Select one): ☐ One Time ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Important Tax Information

Federal Tax - The Plan does not withhold Federal Income tax when processing this distribution; however, the distribution will be reported as ordinary income on the tax form 1099-R. The Plan cannot offer tax guidance. Please consult with your tax advisor on how to report this as a Federal exemption that may be available to you.

Important **State Taxes** - Your state of residence may have differing tax requirements from the federal exemption. If your state mandates that state taxes be withheld at the time of processing this distribution that will be reflected in the net amount of the distribution check **which in turn may result in less than the amount owed being sent to your insurance carrier.**

Authorization on next page.

Authorization

The Plan cannot confirm if you're previous position is considered a "qualified public safety officer" as dictated under the Pension and Protection Act of 2006. I understand that I am self-certifying that I am a qualified public safety officer because I worked as a police officer, firefighter, correction officer, parole officer, probation officer or a member of a rescue squad/ambulance crew and I attained retirement age or retirement due to disability. 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/claim.

I understand these payments are subject to a $3,000 per calendar year maximum, will be distributed pro-rata from all of my pre-tax deferred funds and these payments cannot be distributed from any ROTH funds I may have. I understand the Plan must verify my termination date prior to processing my request. In addition, I understand that there are two payment options available and if I choose to have the payments payable and mailed to me, it is my responsibility to ensure the payments are forwarded to the insurance company by the due date.

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.