New York State
Deferred Compensation Plan
A Plan for Your Future

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

PUBLIC SAFETY OFFICER INSURANCE PREMIUM PAYMENT AUTHORIZATION FORM

PERSONAL DATA

Name (Please Print) _____ Last Four of SSN/Account Number _____

Home Address _____ Date of Birth _____

City _____ State _____ Zip _____ Home Telephone Number _____

Employer or Former Employer _____ Work Telephone Number _____

❑ **This is a change to my home address of record. Please update my account accordingly.**

PAYMENT METHOD

Pursuant to the enclosed Health and/or Long Term Care Insurance premium notice, I hereby authorize the transfer of:

$ _____ to the following insurance carrier. **Premium Due Date _____**

Payment Frequency (select one): ❑Monthly ❑Quarterly ❑Semi-Annually ❑Annually

Insurance Carrier: NYS Employee Insurance Pending Account

Mailing Address: State of NY Dept of Civil Service Employee Benefits Division - Enrollee

City, State, and Zip Code: P.O. Box 645475 Cincinnati, OH 45264-5475

A copy of the insurance premium notice must be included with this form. Your request will be delayed if you do not include a copy of the premium notice. We must receive this form and a copy of the insurance premium notice no later than 15 days prior to the premium due date.

AUTHORIZATION

I hereby authorize the Plan's trustee to pay the Health and Long Term Care Insurance premiums directly to my insurance carrier. I understand that these benefits will be paid directly to the carrier (subject to a $3,000 per year limitation) and will not be made to me. I certify that I am a qualified public safety officer who has retired from employment as a police officer, firefighter, correction officer, parole officer, probation officer, or a member of a rescue squad or ambulance crew because I attained retirement age or for disability.

I understand that funds will be sold pro-rata from my Plan account to pay this premium. Some mutual funds may impose a short-term trade fee. Please read the underlying prospectuses carefully.

I understand the Plan must verify my termination date prior to processing my request. 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

OR Fax to: 1-877-677-4329
When faxing paperwork, please allow two hours from receipt for it to be processed. If your fax is sent after 3 p.m, your paperwork will be processed on the next business day.