



Deferred Compensation Plan Change Form

(212) 306-7760 1-888-DCP-3113 (outside NYC)
Web site: nyc.gov/deferredcomp

DO NOT WRITE IN THIS BOX			
Agency Payroll Code			

Mail (do not fax) completed form to: DEFERRED COMPENSATION PLAN
Bowling Green Station, P.O. Box 93
New York, New York 10274-0093

1 Mark (x) All That Apply: (See page 2 for explanation.)

- 457 Plan - 01 Contribution Account Change
- 457 Plan - 02 Payout Account Change
- 401(k) Plan - 03 Contribution Account Change
- 401(k) Plan - 04 Payout Account Change
- 401(k) Plan Special Rollover - (05) Account Change

2 Change: PLEASE NOTE: THIS IS NOT AN ENROLLMENT FORM

- Address (complete sections 3 and 8)
 - Check this box if you would like a Reminder PIN sent to you.
- Agency/Payroll Code (complete sections 3 and 8)
 - Check this box if you have an outstanding loan.
- Name - attach documentation (complete sections 3, 4 and 8)
- Social Security Number - attach documentation (complete sections 3, 5 and 8)
- E-mail Address - (complete section 3, 6 and 8)
- Beneficiary Election including Beneficiary Address Changes (complete sections 3, 7, 8, and 9)

This type of change may require this form to be notarized.

3 Participant Information

Participant ID or Last 4 Digits of SSN	Date of Birth (MM/DD/YY)	Area Code	Home Telephone	Area Code	Work Telephone	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Last Name as it currently appears on your account				First Name as it currently appears on your account		M.I.
<input type="text"/>				<input type="text"/>		<input type="text"/>
Home Mailing Address - Number and Street					Apt. No.	
<input type="text"/>					<input type="text"/>	
City			State	Zip Code + Four		
<input type="text"/>			<input type="text"/>	<input type="text"/>		

Please Check One Managerial Uniformed Force Civilian Non-Managerial

Agency Name (Not Division) (Cuny employees: please specify name of school)

4 Name Change: Documentation required (See page 2 for explanation.)

New Last Name	New First Name	M.I.
<input type="text"/>	<input type="text"/>	<input type="text"/>

5 Social Security Number Change: Documentation required (See page 2 for explanation.)

Social Security Number as it <u>currently</u> appears on your account:	New Social Security Number:
<input type="text"/>	<input type="text"/>

6 E-mail Address: Add Change

<input type="text"/>



**SECTION 1
PLAN ACCOUNTS**

If you have more than one Plan account, check each account for which the change(s) on the form should apply. Use another Change Form if you wish to designate different beneficiaries for each account.

**SECTION 3
PARTICIPANT INFORMATION**

Address changes will apply to all plans you might have (457, 401(k), 401(k) Special Rollover, and NYCE IRA).

**SECTION 4
NAME CHANGE**

Name changes will apply to all plans you might have (457, 401(k), 401(k) Special Rollover, and NYCE IRA). Acceptable documentation includes: name change order, marriage certificate, divorce decree, driver's license or passport.

**SECTION 5
SOCIAL SECURITY NUMBER CHANGE**

Social Security Number changes will apply to all plans you might have (457, 401(k), 401(k) Special Rollover, and NYCE IRA). Acceptable documentation includes: copy of new Social Security card and driver's license or passport.

**SECTION 7
BENEFICIARY ELECTION**

This form must be notarized if you are changing a beneficiary, adding a beneficiary, or changing the percentage a beneficiary is to receive. This form does not have to be notarized (see section 9 STATEMENT OF NOTARY on page 4) if you are changing the address of an existing beneficiary.

If you are naming a person as your beneficiary, you should select "A Person" in the first box, even if your beneficiary is a minor child. Do not select "A Trust" unless you have already created the trust (or arranged for one to be created under your will). The Plan cannot establish a trust for you.

You must name a beneficiary when you enroll. If you die, your account balance or remaining payments will be paid in this order:

1. To your surviving primary beneficiary(ies);
2. If there are no surviving primary beneficiaries, to your surviving contingent beneficiaries;
3. If there are no surviving primary or contingent beneficiaries, to your surviving spouse;
4. If there is no surviving spouse, to your estate.

You may designate more than one primary beneficiary. You must also indicate the percentage you wish each primary beneficiary to receive upon your death. The total must equal 100%. You may also designate more than one contingent beneficiary. The percentages you wish each contingent beneficiary to receive upon your death must also total 100%. For example, you elect two primary beneficiaries and specify that each primary should receive 50% of your account balance upon your death. You also elect three contingent beneficiaries and specify that one contingent should receive 50% and the other two should receive 25% each (totaling 100%). The contingent beneficiaries will only receive your account in the event there are no surviving primary beneficiaries.

Please note that if you are participating in both the 457 Plan and the 401(k) Plan, changing beneficiaries in one plan will not effect changes in the other plan, unless you indicate otherwise in Section 1 of the Change Form.

Participant ID or Last 4 Digits of SSN

7 Beneficiary Election: Please check this box if you are attaching a list of additional beneficiaries on a separate piece of paper.

I name the following beneficiary(ies) to receive my Deferred Compensation Plan account balance in the event of my death. If more than one beneficiary is named, payment will be made in equal shares to the surviving beneficiaries, unless specified otherwise.

1st	This Beneficiary is (check one)	Status (refer to page 2 for explanation)	Beneficiary's Social Security Number
	<input type="checkbox"/> A Person <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> A Charity/Organization	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="text"/>
Beneficiary's (or Successor Trustee's) Last Name (Include additional information below.)		Beneficiary's (or Successor Trustee's) First Name	
<input type="text"/>		<input type="text"/>	
Beneficiary's (or Successor Trustee's) Home Mailing Address - Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City		State	Zip Code + Four
<input type="text"/>		<input type="text"/>	<input type="text"/>
Percentage to be received		Relationship:	
<input type="text"/> %		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Other	
Additional Trust or Charity/Organization Information			
<input type="text"/>			

2nd	This Beneficiary is (check one)	Status (refer to page 2 for explanation)	Beneficiary's Social Security Number
	<input type="checkbox"/> A Person <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> A Charity/Organization	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="text"/>
Beneficiary's (or Successor Trustee's) Last Name (Include additional information below.)		Beneficiary's (or Successor Trustee's) First Name	
<input type="text"/>		<input type="text"/>	
Beneficiary's (or Successor Trustee's) Home Mailing Address - Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City		State	Zip Code + Four
<input type="text"/>		<input type="text"/>	<input type="text"/>
Percentage to be received		Relationship:	
<input type="text"/> %		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Other	
Additional Trust or Charity/Organization Information			
<input type="text"/>			

3rd	This Beneficiary is (check one)	Status (refer to page 2 for explanation)	Beneficiary's Social Security Number
	<input type="checkbox"/> A Person <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> A Charity/Organization	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="text"/>
Beneficiary's (or Successor Trustee's) Last Name (Include additional information below.)		Beneficiary's (or Successor Trustee's) First Name	
<input type="text"/>		<input type="text"/>	
Beneficiary's (or Successor Trustee's) Home Mailing Address - Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City		State	Zip Code + Four
<input type="text"/>		<input type="text"/>	<input type="text"/>
Percentage to be received		Relationship:	
<input type="text"/> %		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Other	
Additional Trust or Charity/Organization Information			
<input type="text"/>			

4th	This Beneficiary is (check one)	Status (refer to page 2 for explanation)	Beneficiary's Social Security Number
	<input type="checkbox"/> A Person <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> A Charity/Organization	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="text"/>
Beneficiary's (or Successor Trustee's) Last Name (Include additional information below.)		Beneficiary's (or Successor Trustee's) First Name	
<input type="text"/>		<input type="text"/>	
Beneficiary's (or Successor Trustee's) Home Mailing Address - Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City		State	Zip Code + Four
<input type="text"/>		<input type="text"/>	<input type="text"/>
Percentage to be received		Relationship:	
<input type="text"/> %		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Other	
Additional Trust or Charity/Organization Information			
<input type="text"/>			

5th	This Beneficiary is (check one)	Status (refer to page 2 for explanation)	Beneficiary's Social Security Number
	<input type="checkbox"/> A Person <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> A Charity/Organization	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	<input type="text"/>
Beneficiary's (or Successor Trustee's) Last Name (Include additional information below.)		Beneficiary's (or Successor Trustee's) First Name	
<input type="text"/>		<input type="text"/>	
Beneficiary's (or Successor Trustee's) Home Mailing Address - Number and Street			Apt. No.
<input type="text"/>			<input type="text"/>
City		State	Zip Code + Four
<input type="text"/>		<input type="text"/>	<input type="text"/>
Percentage to be received		Relationship:	
<input type="text"/> %		<input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister/Brother <input type="checkbox"/> Other	
Additional Trust or Charity/Organization Information			
<input type="text"/>			

Participant ID or Last 4 Digits of SSN

Please sign form below (section 8 YOUR SIGNATURE). This form must be notarized (section 9 STATEMENT OF NOTARY) if you are changing a beneficiary, adding a beneficiary, or changing the percentage a beneficiary is to receive. This form does not have to be notarized if you are changing the address of an existing beneficiary.

8 Your Signature: I wish to effect the changes noted above in the Deferred Compensation Plan. I affirm that the information is true and accurate.

Signature: _____ Date*: _____ / _____ / _____

9 Statement of Notary:

Important: If this form is being notarized outside of the United States, notarization must be performed by the U.S. Consulate.

State of _____)
) SS.:
 County of _____)

On _____* before me, the undersigned, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

 (Signature and office of individual taking acknowledgment)

* The date you sign the form must match the date on which the signature is notarized.

Do Not Write in This Box	Initials	Date	PMS Document #	Effective Date (MM/DD/YYYY)
	DCP Database	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Payroll	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>