



Enrollment Form

For Part-Time Employees In 457 Public Employer Deferred Compensation Plans

Voya Retirement Insurance and Annuity Company
P.O. Box 990063
Hartford, CT 06199-0063

Fax Number: 1-800-643-8143

In this form, Voya Retirement Insurance and Annuity Company may also be referred to as the Company. Eligibility to receive Employer Contributions is determined by the Employer. Completion of this Enrollment Form does not establish your eligibility to receive Employer Contributions.

Information About You

Please print.

Changes to the Social Security No. or Date of Birth must be initialed by the Participant.

Employer Name	City of Cambridge		Billing Group No.	VK4307	
Participant Name (First, Middle Initial, Last)				Social Security No.	
Participant Resident Address (No. & Street)				PO Box	
City/Town				State	Zip Code
Date of Birth	Home Telephone No.	Work Telephone No.			
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Anti-Fraud Statement

We are required by the insurance regulations of your state to provide you with the following information: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Mandatory Salary Reduction

I acknowledge that I have received the Fixed Annuity Disclosure Booklet and understand that all contributions will be deposited into the Voya Fixed Account.

Signature

This Agreement is made between the Participant and the Employer. I understand that the information indicated above will remain in effect until later changed or revoked by me. I also understand that I am required to contribute a mandatory amount (as defined by my Employers Plan) into the Voya Fixed Account until my status as a Part Time employee is otherwise changed as permitted by the plan.

Participant's Signature	Date (mm/dd/yyyy)

BENEFICIARY DESIGNATION – NON-ERISA

Voya Retirement Insurance and Annuity Company ("VRIAC")
 Voya Institutional Plan Services, LLC ("VIPS")
Members of the Voya™ family of companies
 One Orange Way, Windsor, CT 06095-4774
 Phone: 800-262-3862 Fax: 800-643-8143



As used on this form, the term "Voya," "Company," "we," "us" or "our" refer to VRIAC or VIPS as your plan's funding agent and/or administrative services provider. Contact us for more information.

For assistance in completing this form, please call our Customer Service Center at 800-262-3862.

GOOD ORDER

Good order is receipt at the designated location of this form accurately and entirely completed, and includes all necessary signatures. If this form is not received in good order, as we determine, it may be returned to you for correction and processed upon re-submission in good order at our designated location.

REQUEST TYPE

☐ Initial Designation ☐ Change to Designation

1. PLAN INFORMATION *(Required)*

Plan Name _____ Billing Group/Plan # _____

2. ACCOUNT HOLDER INFORMATION *(Required)*

Name *(last, first, middle initial)* _____ SSN *(Required)* _____

Work Phone *(Include extension.)* _____ Home Phone _____

3. BENEFICIARY INFORMATION *(Changes must be initialed by the Account Holder.)*

Subject to the terms of my Employer's Plan, I request that any sum becoming due upon my death be payable to the beneficiary(ies) designated below. I understand this designation shall revoke all prior beneficiary designations made by me under my Employer's Plan. *(All designations must be in whole percentages. Total percentage must equal 100% for Primary Beneficiary and 100% for Contingent Beneficiary, if designated. Example: 33%, 33%, 34%.)*

	Enter Complete Legal Name, Address and Phone #	Date of Birth (mm/dd/yyyy)	Relationship	SSN	Percentage of Benefit
☐ Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

(Beneficiaries continued on next page.)

3. BENEFICIARY INFORMATION *(Continued)*

	Enter Complete Legal Name, Address and Phone #	Date of Birth (mm/dd/yyyy)	Relationship	SSN	Percentage of Benefit
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

☐ Please check if additional beneficiaries are noted on the back of this form and follow same format as above.

4. SIGNATURES

Unless otherwise noted:

- If more than one Beneficiary is designated, payment will be made in the percentages designated (or in equal shares) to the **Primary Beneficiaries** who survive the Account Holder or Annuitant. Or, if none survives the Account Holder or Annuitant, payment will be made in the percentages designated (or in equal shares) to the **Contingent Beneficiaries** who survive the Account Holder or Annuitant.
- If no Beneficiary survives the Account Holder or Annuitant, payment will be made pursuant to the terms of the Plan.
- If you name an Estate or Trust as beneficiary, contact your Plan Administrator for more information.

Account Holder Signature _____ Date (mm/dd/yyyy) _____

City and State Where Signed _____

Witness Name *(Please print.)* _____

Witness Signature _____ Date (mm/dd/yyyy) _____

(Participant's signature must be witnessed. Witness must be a person of legal age other than designated beneficiary. The witness need not be a Notary Public.)

MAIL OR FAX INSTRUCTIONS *(Please keep a copy for your records.)*

Please return the completed form to: Voya Retirement Insurance and Annuity Company
PO Box 990063
Hartford, CT 06199-0063
Fax: 800-643-8143