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		Billing Group No. VFG368
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. ( )

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 [002].

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 Form

Part-Time Employee - Section 457
Deferred Compensation Program

Participant Information

Participant Name (*Last, First, Middle Initial*)	Social Security No.	Date of Birth (mm/dd/yyyy)	Sex (M/F)
Street Address	City	State	Zip
Work Department (Location)	Work Telephone		Home Telephone

Primary Beneficiary Information

Beneficiary Name (*complete legal name required*)	Beneficiary Social Security No.		Primary Beneficiary Percentage
Beneficiary Address	City	State	Zip Code
Beneficiary Date of Birth (*mm/dd/yyyy*)			Relationship

Contingent Beneficiary Information

Contingent Beneficiary Name (*complete legal name required*)	Contingent Benef. Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Address	City	State	Zip Code
Contingent Beneficiary Date of Birth (*mm/dd/yyyy*)			Relationship

Contingent Beneficiary Name (*complete legal name required*)	Contingent Benef. Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Address	City	State	Zip Code
Contingent Beneficiary Date of Birth (*mm/dd/yyyy*)			Relationship

Contingent Beneficiary Name (*complete legal name required*)	Contingent Benef. Social Security No.		Contingent Beneficiary Percentage
Contingent Beneficiary Address	City	State	Zip Code
Contingent Beneficiary Date of Birth (*mm/dd/yyyy*)			Relationship

Signature

I have read and acknowledged the above provisions and those contained on attachments to this Agreement. I understand that my elections above will remain effective until later changed or revoked.

Participant's Signature (*Required*) **Printed Name** **Date** (*required*) (*mm/dd/yyyy*)