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: 800-584-6001

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 immediate assistance in designating or changing your beneficiary designation please call our Customer Service Center at 800-584-6001. If you contact the Customer Service Center via the 800 number you do not need to complete this form to designate your beneficiary.

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)*

You are permitted to designate a Beneficiary under both Plans. If you participate in both Plans and wish to designate a different Beneficiary(ies) under each Plan, you must complete two separate forms and indicate for which Plan the designation applies. If you wish to designate the same Beneficiary(ies) under both Plans, you only need to complete one form and indicate that the same designation applies to both Plans.

☐ 457 Plan Name Johnson County 457 Deferred Compensation Plan Plan # 666813

☐ 401(a) Plan Name Johnson County Supplemental Retirement Plan Plan # 666814

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/TIN	Percentage of Benefit
☐ Primary					
☐ 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/TIN	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.

Unless otherwise noted:

1. 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.
2. If no Beneficiary survives the Account Holder or Annuitant, payment will be made pursuant to the terms of the Plan.

4. TRUST CERTIFICATION *(Only complete if naming a Trust as a Beneficiary.)*

By signing below, I certify that:

A. Name of Trust or Trust instrument _____

B. The Trust or Trust instrument identified above, is in full force and effect and is a valid Trust or Trust instrument under the laws of the State or Commonwealth of _____.

C. The Trust is irrevocable, or will become irrevocable, upon my death.

D. All beneficiaries are individuals and are identifiable from the terms of the Trust.

In the event that any of the information provided above changes, I will provide Voya with the changes, within a reasonable period of time.

By designating a Trust, additional documentation and/or certification may be required.

5. SIGNATURES

I hereby certify under the pains and penalties of perjury that information I furnished herein is true, accurate and complete.

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

City and State Where Signed _____

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