

# BENEFICIARY DESIGNATION STATE OF NEVADA DEFERRED COMPENSATION PLAN

Voya Retirement Insurance and Annuity Company ("VRIAC")  
 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 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. Please indicate your employer.)*

Employer	Plan #
<input type="checkbox"/> State of Nevada	666783
<input type="checkbox"/> Alliance Partner	666970
<input type="checkbox"/> Nevada System of Higher Education (NSHE)	666971

### 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 <i>(mm/dd/yyyy)</i>	Relationship	SSN/TIN	Percentage of Benefit
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> 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
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

Please check if additional beneficiaries are noted on a separate sheet 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 \_\_\_\_\_

Witness Name *(Please print.)* \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

*(Account Holder's signature must be witnessed. Witness must be a person of legal age, and someone other than a designated beneficiary.)*

**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