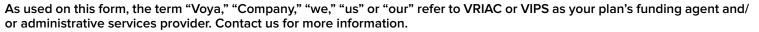
BENEFICIARY DESIGNATION – NON-ERISA

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



For immediate assistance in designating or changing your beneficiary designation please call Customer Service at 800-584-6001. If you contact Customer Service 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)

Plan Name District of Columbia Deferred Compensation Plan

2. ACCOUNT HOLDER INFORMATION (Required)

Name (last, first, middle initial) _____

Work Phone (Include extension.) _____

Home Phone

Billing Group/Plan # 666775

_ SSN (Required) _____

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 (Optional)	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 (Optional)	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 l	be a person of legal age other than designated beneficiary. The witness

(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			