Beneficiary Designation

- ☐ Initial Designation
- ☐ Change to Designation

Mail or Fax completed form to:
ING Life Insurance and Annuity Company
P.O.Box 990063
Hartford, CT 06199-0063
Fax: 800-643-8143

Plan Information

Plan Name	Plan Number
State of Connecticut 403(b) Plan	**666802**

Participant Information

Participant Name *(Last, First, Middle Initial)*	Social Security Number

Daytime Telephone Number	Evening Telephone No.
( )	( )

Beneficiary Information

Please print

Changes must be initialed by the Participant.

If additional space is needed, attach a separate page and include all the information shown here.

* *Total Percentage must equal **100%** for Primary Beneficiary and **100%** for Contingent Beneficiary (if designated).*

** ***Contingent Beneficiary(ies)** will only receive payment if all Primary Beneficiaries have predeceased the Participant.*

Beneficiary Name and Address *(complete legal name required)*	☑ **Primary Beneficiary**	Percentage*

Relationship	Social Security Number	Date of Birth *(mm/dd/yyyy)*

Beneficiary Name and Address *(complete legal name required)*	☐ **Primary Beneficiary** OR ☐ **Contingent Beneficiary****	Percentage*

Relationship	Social Security Number	Date of Birth *(mm/dd/yyyy)*

Beneficiary Name and Address *(complete legal name required)*	☐ **Primary Beneficiary** OR ☐ **Contingent Beneficiary****	Percentage*

Relationship	Social Security Number	Date of Birth *(mm/dd/yyyy)*

Beneficiary Name and Address *(complete legal name required)*	☐ **Primary Beneficiary** OR ☐ **Contingent Beneficiary****	Percentage*

Relationship	Social Security Number	Date of Birth *(mm/dd/yyyy)*

Signatures

Unless otherwise noted:

- 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 above. I understand this designation will supercede all prior Beneficiary designations made by me under my Employer's Plan.
- 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 Participant or, if none survive the Participant, payment will be made in the percentages designated *(or in equal shares)* to the **Contingent Beneficiaries** who survive the Participant.
- If a percentage is not designated, it will be assumed that you wish the value of your Plan Account to be split equally among all Designated Beneficiaries.
- If no Beneficiary survives the Participant, payment will be made pursuant to the terms of the Plan.

Signed in *(City/Town and State)*	Date of Participant's Signature ***(required)*** *(mm/dd/yyyy)*
Participant Name *(please print)*	Witness Name *(please print)*
Participant's Signature ***(required)***	Witness' Signature *(see instructions)*