

BENEFICIARY DESIGNATION – NON-ERISA

ING Life Insurance and Annuity Company (“ILIAC”)
 ING Institutional Plan Services, LLC (“IIPS”)
Members of the ING family of companies
 One Orange Way, Windsor, CT 06095-4774
 Phone: 800-584-6001



As used on this form, the term “ING,” “Company,” “we,” “us” or “our” refer to ILIAC or IIPS 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(b) Plan Name West Virginia Retirement Plus Billing Group/Plan # 666825

401(a) Plan Name West Virginia Retirement Plus Match Plan Billing Group/Plan # 666826

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 and Address	Date of Birth (mm/dd/yyyy)	Relationship	SSN	Percentage of Benefit
<input type="checkbox"/> Primary					
<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 and Address	Date of Birth <i>(mm/dd/yyyy)</i>	Relationship	SSN	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					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<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 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, if none survives the Account Holder, payment will be made in the percentages designated (or in equal shares) to the **Contingent Beneficiaries** who survive the Account Holder.
- If no Beneficiary survives the Account Holder, 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 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: ING Life Insurance and Annuity Company
PO Box 990063
Hartford, CT 06199-0063
Fax: 800-643-8143