RESET FORM

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

ING
Your future. Made easier.®

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)*

Plan Name District of Columbia Deferred Compensation Plan Billing Group/Plan # 666775

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 *(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 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