INPRS
INDIANA PUBLIC RETIREMENT SYSTEM

Legislators' Retirement System

BENEFICIARY DESIGNATION

(Defined Contribution and Rollover Pre-Tax Contribution)

PERSONAL INFORMATION *(Please print clearly using black or blue ink.)*

NAME: _____ **SOCIAL SECURITY NUMBER*:** _____

ADDRESS *(number and street)*: _____ **APARTMENT:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DAY TELEPHONE: _____ **EVENING TELEPHONE:** _____

EMAIL: _____

DATE OF BIRTH: _____/_____/_____ **PENSION ID:** _____

INSTRUCTIONS

*Your Social Security number is being requested by this agency pursuant to the requirements of IRS Code 3405. This disclosure is mandatory and this form cannot be processed without this information.

1. If you designate a trust as a beneficiary, please include the trust name and trust date.

2. If you list more than one beneficiary, the total of all Primary and/or Contingent Beneficiaries must be in whole increments and equal 100%. If you need to add additional names, please use the back of this form clearly labeling Primary or Contingent Beneficiaries.

3. If your Primary Beneficiary(ies) die(s) before you, then Plan benefits will be distributed to Contingent Beneficiary(ies).

PRIMARY BENEFICIARY(IES)

Full Name and Address *(number and street, city, state, and ZIP code)*	Social Security Number*	Date of Birth	Relationship to You	Percent of Benefit** *(Whole % only, must total 100%)*
1		___/___/_____ MM DD YYYY		___ .00%
2		___/___/_____ MM DD YYYY		___ .00%
3		___/___/_____ MM DD YYYY		___ .00%
4		___/___/_____ MM DD YYYY		___ .00%
**A Percent of Benefit must be provided for each Primary Beneficiary, even if only a single beneficiary is listed. The percent assigned to each Primary Beneficiary must be in whole increments and must total to 100%. Both of these requirements must be met in order for this form to be accepted and processed.				**100%**

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CONTINGENT BENEFICIARY(IES)

Full Name and Address *(number and street, city, state, and ZIP code)*	Social Security Number*	Date of Birth	Relationship to You	Percent of Benefit** *(Whole % only, must total 100%)*
1		___/___/_____ MM DD YYYY		___.00%
2		___/___/_____ MM DD YYYY		___ ___.00%
3		___/___/_____ MM DD YYYY		___ ___.00%
4		___/___/_____ MM DD YYYY		___ ___.00%
****A Percent of Benefit must be provided for each Contingent Beneficiary, even if only a single beneficiary is listed. The percent assigned to each Contingent Beneficiary must be in whole increments and must total to 100%. Both of these requirements must be met in order for this form to be accepted and processed.**				**100%**

AUTHORIZATION

I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary in writing with the Legislators' Defined Contribution Plan and that by doing so, I revoke all prior designations.

I understand that if none of the above-named beneficiary(ies) survive me, all benefits under the Plan will be distributed according to the provisions stated in the official plan document.

I hereby certify that the information I furnished herein is true, accurate and complete.

PARTICIPANT SIGNATURE _____ **DATE** _____
(month, day, year)

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CHECKLIST

PLEASE REVIEW YOUR APPLICATION CAREFULLY.

- ☐ Read the required instructions.
- ☐ Provided complete personal information including name, Social Security number, Pension ID.
- ☐ Provided your Primary Beneficiary(ies). Make sure you have completed all the sections and that your percentages of benefit total 100%.
- ☐ Completed the Contingent Beneficiaries section (only if you want to have contingent beneficiaries). The total percent equals 100% of benefit.
- ☐ Listed the name, address, Social Security number, birth date and relationship of all Beneficiaries.
- ☐ Signed and dated your Beneficiary Designation (Authorized Signature). Must be dated in the last ninety (90) days.

You will receive a confirmation statement on your beneficiary elections. If you have any questions or need to obtain additional plan or account information, please go online at MyINPRSretirement.org or call the Indiana Public Retirement System Service Center at 1-844-GO-INPRS (TTY/TTD users call 1-800-579-5708). Customer Service Associates are available Monday through Friday, 8:00 A.M. to 8:00 P.M. Eastern Time (excluding stock market holidays).

If your application is complete, please mail or fax the application and any additional documents to:

VIA FAX
Voya Financial
Attn: Indiana Public Retirement System
1-844-265-5840

VIA MAIL
Voya Financial
Attn: Indiana Public Retirement System
P.O. Box 389
Hartford, CT 06141

VIA OVERNIGHT DELIVERY
Voya Financial
Attn: Indiana Public Retirement System
One Orange Way
Windsor, CT 06095