



PERSONAL INFORMATION (please print clearly using black or blue ink)

NAME: _____ SSN (LAST 4 DIGITS): XXX - XX - _____
 ADDRESS: _____ APT: _____
 CITY: _____ STATE: _____ ZIP CODE: _____
 DAY PHONE: _____ EVENING PHONE: _____
 EMPLOYEE ID: _____ EMAIL: _____ DATE OF BIRTH: ____/____/____

INSTRUCTIONS

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 or a separate piece of paper 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).
4. You may make or change your beneficiary designations by going online at milwaukeeedcp.com or speaking with a Customer Service Associate at 1-844-360-6327 (TTY/TTD users call 1-800-579-5708).

PRIMARY BENEFICIARY(IES)

Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
2 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
3 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .00%
4 _____ _____ _____	_____	____/____/____ M M D D Y Y Y Y		___ __ .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%

**City of Milwaukee Deferred Compensation Plan
BENEFICIARY DESIGNATION FORM**

CONTINGENT BENEFICIARY(IES)				
Full Name and Address	Social Security Number	Date of Birth	Relationship to You	Percent of Benefit* (Whole % only, must total 100%)
1 _____ _____ _____	_____	___/___/___ M M D D Y Y Y Y		___ __ .00%
2 _____ _____ _____	_____	___/___/___ M M D D Y Y Y Y		___ __ .00%
3 _____ _____ _____	_____	___/___/___ M M D D Y Y Y Y		___ __ .00%
4 _____ _____ _____	_____	___/___/___ M M D D Y Y Y Y		___ __ .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
<p>I understand that I may revoke or change this designation at any time by filing a new designation of beneficiary in writing with the City of Milwaukee 457 Deferred Compensation Plan and that by doing so, I revoke all prior designations.</p> <p>I understand that if none of the above-named beneficiary(ies) survive me, all benefits under the Plan will be distributed according to state law.</p> <p>I hereby certify that the information I furnished herein is true, accurate and complete.</p> <p>PARTICIPANTSIGNATURE _____ DATE _____</p>

CHECKLIST

PLEASE REVIEW YOUR APPLICATION CAREFULLY.

- Read the required instructions.
- Provided complete personal information including name and SSN (Last 4 digits)
- 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 90 days.
- Made a copy for your records and send the original to Voya Financial.

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 milwaukeeedcp.com or call the City of Milwaukee Deferred Compensation Plan Service Center at 1-844-360-6327 (TTY/TTD users call 1-800-579-5708). Customer Service Associates are available Monday through Friday, 7:00 A.M. to 7:00 P.M. Central 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: City of Milwaukee
Deferred Compensation Plan
1-844-265-5835

VIA MAIL

Voya Financial
Attn: City of Milwaukee
Deferred Compensation Plan
PO Box 389
Hartford, CT 06141

VIA OVERNIGHT DELIVERY

Voya Financial
Attn: City of Milwaukee
Deferred Compensation Plan
One Orange Way
Windsor, CT 06095