Definition of OBRA

Part-Time, Seasonal, and Temporary Employees of the Commonwealth of Massachusetts or an electing Massachusetts local government employer

The Omnibus Budget Reconciliation Act of 1990 (OBRA) expanded the definition of "employment" for Social Security coverage and FICA tax purposes to include services performed after July 1, 1991 by a state or local government employee, unless the employee is a participant of the employer's retirement system at the time service is rendered or is already covered under an agreement between the employer and the Secretary of Health and Human Services (referred to as Section 218 agreement).

- Most full-time, state or local public employees are participants in their employer's retirement system. By virtue of that participation, full-time service is not covered employment for purposes of Old Age Survivors and Disability Insurance (OASDI) portion of taxes under the Federal Insurance Contributions Act (FICA), sometimes called Social Security tax, on the wages of employees paid by the employer with respect to employment.

- Generally temporary, seasonal and part-time employees are not participants of their employer's retirement system and their employment may be excluded from mandatory Social Security coverage provided they participate in an appropriate alternative plan under OBRA.

- All employees classified as OBRA must make mandatory contributions equal to 7.5% of gross compensation per pay period. Contributions and any earnings are tax-deferred, meaning taxes are not due until distributed, and are invested in the Voya Fixed Account. Distributions of benefits are permitted upon severance from employment, retirement or death.

If you have questions or would like further information about OBRA mandatory accounts, please contact (800) 584-6001.

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Enrollment Form

For Part-Time Employees In 457 Public Employer Deferred Compensation Plans

Voya Retirement Insurance and Annuity Company
P.O. Box 990063
Hartford, CT 06199-0063

Fax Number: 1-800-643-8143

In this form, Voya Retirement Insurance and Annuity Company may also be referred to as the Company. Eligibility to receive Employer Contributions is determined by the Employer. Completion of this Enrollment Form does not establish your eligibility to receive Employer Contributions.

Information About You

Please print.

Changes to the Social Security No. or Date of Birth must be initialed by the Participant.

City of Medford, MA

Billing Group No. VK4318

Participant Name (*First, Middle Initial, Last*)	Social Security No.

Participant Resident Address *(No. & Street)*	PO Box

City/Town	State	Zip Code

Date of Birth	Home Telephone No.	Work Telephone No.
	( )	( )

Anti-Fraud Statement

We are required by the insurance regulations of your state to provide you with the following information: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Mandatory Salary Reduction

I acknowledge that I have received the Fixed Annuity Disclosure Booklet and understand that all contributions will be deposited into the Voya Fixed Account.

Signature

This Agreement is made between the Participant and the Employer. I understand that the information indicated above will remain in effect until later changed or revoked by me. I also understand that I am required to contribute a mandatory amount (as defined by my Employers Plan) into the Voya Fixed Account until my status as a Part Time employee is otherwise changed as permitted by the plan.

Participant's Signature	Date *(mm/dd/yyyy)*

RESET FORM

BENEFICIARY DESIGNATION – NON-ERISA

Voya Retirement Insurance and Annuity Company ("VRIAC")
Voya Institutional Plan Services, LLC ("VIPS")
Members of the Voya® family of companies
One Orange Way, Windsor, CT 06095-4774
Phone: 800-584-6001

As used on this form, the term "Voya," "Company," "we," "us" or "our" refer to VRIAC or VIPS 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 _____ Plan # _____

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/TNN	Percentage of Benefit
☐ Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

(Beneficiaries continued on next page.)

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TM: BENEMAINT

3. BENEFICIARY INFORMATION *(Continued)*

	Enter Complete Legal Name, Address and Phone #	Date of Birth *(mm/dd/yyyy)*	Relationship	SSN/TIN	Percentage of Benefit
☐ 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.

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.

4. TRUST CERTIFICATION *(Only complete if naming a Trust as a Beneficiary.)*

By signing below, I certify that:

A. Name of trust or trust Instrument: _____

B. The trust or trust instrument identified above, is in full force and effect and is a valid trust or trust instrument under the laws of the State or Commonwealth of _____.

C. The trust is irrevocable, or will become irrevocable, upon my death.

D. All beneficiaries are individuals and are identifiable from the terms of the Trust.

In the event that any of the information provided above changes, I will provide Voya with the changes, within a reasonable period of time.

By designating a Trust, additional documentation and/or certification may be required.

5. SIGNATURES

I hereby certify under the pains and penalties of perjury that information I furnished herein is true, accurate and complete.

Account Holder Signature _____ Date *(mm/dd/yyyy)* _____

City and State Where Signed _____

MAIL OR FAX INSTRUCTIONS *(Please keep a copy for your records.)*

Please return the completed form to:

Voya Retirement Insurance and Annuity Company
PO Box 990063
Hartford, CT 06199-0063
Fax: 800-643-8143

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