



# 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.*

<b>Information About You</b>  <i>Please print.</i>  <i>Changes to the Social Security No. or Date of Birth must be initialed by the Participant.</i>	Employer Name		Billing Group No.	
	City of Newton		VK4314	
	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.		
	( )	( )		
<b>Anti-Fraud Statement</b>	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.			
<b>Mandatory Salary Reduction</b>	I acknowledge that I have received the Fixed Annuity Disclosure Booklet and understand that all contributions will be deposited into the Voya Fixed Account [002].			
<b>Signature</b>	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)	