



Participation Agreement

Participant Information

Mandatory OBRA Contributions

Mail or Fax to:
ING Life Insurance and Annuity Company
 151 Farmington Avenue
 Hartford, CT 06156-7780
 Fax: 1-860-723-9636

Commonwealth of Massachusetts Deferred Compensation Plan

ING Life Insurance and Annuity Company will be defined as "the Company", "we", "us", or "our" in this document. Please return this form to your Payroll Location. Please type or print clearly in ink.

Participant Status	Which of the following are you: <input type="checkbox"/> New Participant to the Mandatory OBRA Deferred Compensation Plan <i>(Have never enrolled or contributed before)</i> <input type="checkbox"/> Rehired Participant to the Mandatory OBRA Deferred Compensation Plan <i>(Have contributed under the same or different Employer/Work Location)</i> Indicate Employer/Work Location: _____ <input type="checkbox"/> Multiple Participant <i>(Are currently contributing from more than one Employer/work location)</i> Indicate Employer/Work Location: _____			
Profile Information <i>Please print.</i>	Plan Name Commonwealth of Massachusetts Deferred Compensation Plan		Billing Group No. VFZ755	
Employer/Work Location <i>(State, City/Town, or Authority)</i>		Payroll Location No.		
Participant Name <i>(First, Middle Initial, Last)</i>		Social Security No.		
Participant Resident Address <i>(No. & Street)</i>		PO Box		
City/Town		State	Zip Code	
Work Telephone No. ()		Extension	Home Telephone No. ()	
Date of Hire <i>(mm/dd/yyyy)</i>	Date of Birth <i>(mm/dd/yyyy)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S	
Salary Reduction Percentage	7.5% Mandatory Salary Reduction - amounts deducted will be invested in The Income Fund (Fund #508).			
Anti-Fraud Statement	Certain states require the following statement: 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.			
Participant Certification and Signature	This Agreement is made between me, the Participant and my Employer with respect to my participation in the Commonwealth of Massachusetts Deferred Compensation Plan. I understand that the information indicated above will remain effective until later changed or revoked by me. I also understand that I am required to contribute at a rate of 7.5% until my status as an OBRA Employee is otherwise changed as permitted by the Plan. If I have another Mandatory OBRA Deferred Compensation Account, any changes on this form will update my existing account. I understand that in the event of my death my deferred compensation benefit will be payable to those identified by the personal representative as being entitled to the residuary share of my estate. If I want to select a Beneficiary other than the foregoing, I need to obtain a Beneficiary Designation Change Form from the website www.ingretirementplans.com/custom/mass or contact a Customer Service Associate.			
Participant's Signature			Date <i>(mm/dd/yyyy)</i>	
To be Completed by Payroll Location	Please update your Payroll Records and immediately forward this form to our Hartford Service Center at the address above.			
Payroll Effective Date	Payroll Contact Name	Date Forwarded to Hartford Service Center		
If State Employer, Name Department/Agency Name		Department/Agency Subcode		



Participation Agreement Disclosure

ING Life Insurance and Annuity Company
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Hartford, CT 06156-7780

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<p>Good Order</p>	<p>Good Order is receipt at our Hartford Service Center of this form and any other required information or document that has been accurately and entirely completed, and includes the signature of you, the Participant. Forms and any other requested information not received in Good Order, as determined by us, may be returned to you for correction and processed upon re-submission in Good Order at our Hartford Service Center.</p>
<p>Disclosures</p>	<p>As a result of the Omnibus Budget Reconciliation Act of 1990 (OBRA), pursuant to Internal Revenue Code (IRC), Section 3121(b)(7), and in accordance with Massachusetts General Laws, Chapter 29, Section 64D, you are required to contribute at least 7.5% of your salary or wages to an eligible Section 457 Deferred Compensation Plan. Your contributions will be invested in The Income Fund.</p> <p>This Agreement is a Legally Binding Contract This Agreement, together with the Plan document (<i>and any documents incorporated by reference into the Plan</i>), constitutes the entire contract between you and your Employer with respect to your participation in the Commonwealth of Massachusetts Deferred Compensation Plan. Our Representative cannot change the terms of this Agreement or the Plan.</p> <p>Deferred Compensation Funds are Held in Trust All amounts of compensation deferred under the Plan, all property and rights purchased under the Plan, and all income attributable to such amounts, property, or rights, placed in investment products authorized under the Commonwealth's Plan in accordance with Massachusetts General Law Chapter 29, Section 64, shall be held in trust for the exclusive benefit of Participants and their Beneficiaries.</p> <p>Compliance with Internal Revenue Code The Commonwealth may take any action that may be necessary to ensure that your participation in the Plan is in compliance with the applicable requirements of the IRC.</p> <p>Plan Investment Options The Commonwealth has sole discretion to select the investment options available under the Plan. You acknowledge that the Commonwealth, the Commonwealth agencies, departments, sub-divisions, or instrumentalities electing to participate in the Plan are not responsible for account balance gains and losses resulting from the investment performance of these options. The Income Fund is the only available investment option for your Mandatroy OBRA Contributions.</p> <p>Plan Administration Fee In addition to any fees, charges, and expenses under the Plan Investment Options, we will deduct an administration fee from the total account value for each Plan Participant. This fee is \$1.583 from your account balance, deducted monthly.</p> <p>Voluntary Contributions If you wish to contribute more than 7.5%, contact your ING Local Offices (<i>toll-free</i>) at 1-877-721-5894.</p> <p>Plan Distribution Restrictions Federal and state tax laws impose certain distribution restrictions on your Participant Deferred Compensation Account under the Plan, because your Plan is designed to help you save for your retirement. Under certain circumstances as defined by the IRC you may be allowed certain distributions while in-service for an unforeseeable emergency, de-minimus withdrawal (<i>under limited circumstances</i>), or Plan-to-Plan Transfers (<i>as long as the amounts transferred are invested in an account bearing a reasonable rate of interest to meet the requirements of Chapter 29, Section 64D of the Massachusetts General Laws and Section 3121(b)(7)(F) of the IRC and regulations thereunder</i>). Upon separation from service, all mandatory contributions will be distributed by lump sum payment.</p> <p>Maximum Contributions All contributions collectively made to the Deferred Compensation Plan can not exceed the maximum annual deferral limits imposed by the IRC.</p> <p>Beneficiary Information The deferred compensation benefit will be payable to those identified by the personal representative as being entitled to the residuary share of the deceased Participant's estate. If you would like to select a Beneficiary other than the foregoing, you must obtain a Beneficiary Designation Change Form from the custom website at www.ingretirementplans.com/custom/mass or contact a Customer Service Associate at 1-800-584-6001, Monday-Friday, 8:00 a.m.-10:00 p.m. and Saturday, 8:00 a.m.-4:00 p.m. Eastern Standard Time. The Beneficiary information will be effective when our Hartford Service Center receives the form in Good Order.</p>
<p>Changes to Your Account Information</p>	<p>Name, Address, or Beneficiary Changes For changes to your Name, Address, or Beneficiary, please contact our Customer Service Associates (<i>toll-free</i>) at 1-800-584-6001, Monday-Friday, 8:00 a.m.-10:00 p.m. and Saturday, 8:00 a.m.-4:00 p.m., Eastern Standard Time.</p>