ONE CITY. ONE JACKSONVILLE

City of Jacksonville
Benefits Division
117 West Duval Street, Suite 150
Jacksonville, FL 32202
Phone: (904) 255 - 5555

ACTIVE - FULL TIME EMPLOYEE

SSN: _____ **Email Address:** _____

Group Life Insurance Beneficiary Form **Date of Birth:** _____ **Phone Number :** _____

EIN	Last Name	First Name	MI	Department

COJ GROUP LIFE BASIC & SUPPLEMENTAL					Percentage must equal 100%
PRIMARY BENEFICIARY NAME(S)	RELATIONSHIP	BIRTH DATE	ADDRESS	PHONE	%
1					
2					
3					
4					

CONTINGENT BENEFICIARY NAME(S) (ONLY PAYABLE IF THERE ARE NO SURVIVING PRIMARY BENEFICIARIES)					
1					
2					
3					
4					

SIGNATURE : _____ **DATE SIGNED :** _____

Please DO NOT sign until you are in the presence of a Benefits Representative.

Notary required if you mail this form to the Employee Benefits Office.

Notary Stamp: **Benefits Staff Signature:** _____

Notary signature: _____ **Date:** _____

Date Notarized: _____ _____