ONE CITY. ONE JACKSONVILLE

City of Jacksonville, Florida
Employee Services Department
City Hall, 117 West Duval St., Suite 150
Jacksonville, Florida 32202

ACTIVE - FULL TIME EMPLOYEE Group Life Insurance Beneficiary Form

Email Address : _____

Phone Number : _____

Employee's SSN	Last Name	First Name	MI	Date of Birth	Date Employed	Department

PRIMARY BENEFICIARY NAME(S)	RELATIONSHIP	BIRTH DATE	ADDRESS	PHONE	Must Equal 100%
1					
2					
3					
4					
5					

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

SIGNATURE : _____ **DATE SIGNED :** _____

Please DO NOT sign until you are in the presence of a Benefit Representative
Notary only required if you do not hand deliver this form to the Compensation and Benefits Office

Notary Signature : _____

Date Notarized : _____

Notary Stamp : _____

C & B Staff Signature: _____

Date: _____