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

ONE CITY. ONE JACKSONVILLE

FORMER ELECTED OFFICIALS Group Life Insurance Beneficiary Form

Email Address: _____

Phone Number: _____

FEO'S SSN	Last Name	First Name	MI	Date of Birth	Department

I understand that a check or money order made payable to the Tax Collector's Office for this benefit must be sent to the Compensation & Benefits Office no later than the 15th day of each month.
I may cancel this policy at any time by submitting written notice to the Compensation & Benefits office.
Check your election:

- ☐ **Basic = 2X Annual Salary (reduced to 65% at age 70) with a maximum benefit of $100,000.**
- ☐ **Supplemental = 2X Annual Salary (reduced to 65% at age 70) with a maximum benefit of $100,000. Must be enrolled prior to termination.**
  This coverage is calculated at the active supplemental employee rate.

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: _____