



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

ONE CITY. ONE JACKSONVILLE

FORMER ELECTED OFFICIAL

SSN: _____ **Email Address:** _____

Group Life Insurance Beneficiary Form

Date of Birth: _____ **Phone Number :** _____

EIN _____ **Last Name** _____ **First Name** _____ **MI** _____ **Separation Date** _____ **Department** _____

Note: Must have worked four uninterrupted years.

Check your election:

- Basic = 2X Annual Salary (reduced to 65% at age 70) with a maximum benefit of \$100,000.00**
- Supplemental = 1X or 2X Annual Salary (reduced to 65% at age 70) with a maximum benefit of \$100,000.00; calculated at the active supplemental employee rate.**

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						

I understand that a check or money order made payable to Tax Collector for this benefit must be received in the Compensation & Benefits Office no later than the 5th day of each month.

SIGNATURE : _____ **DATE SIGNED :** _____

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

Notary required if you mail this form to the Compensation and Benefits Office

Notary Stamp:

C & B Staff Signature:

Notary signature: _____

Date: _____

Date Notarized: _____