



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

ONE CITY. ONE JACKSONVILLE

**SAFETY OFFICERS AND FIREFIGHTERS
 GROUP LIFE INSURANCE, SUPP LIFE, STATUTORY DEATH POLICY STATE AND FEDERAL BENEFIT**

ACTIVE - FULL TIME EMPLOYEE
Group Life Insurance Beneficiary Form

SSN: _____ **Email Address:** _____
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						

STATUTORY DEATH POLICY (STATE & FEDERAL)

	PRIMARY BENEFICIARY NAME(S)	RELATIONSHIP	BIRTH DATE	ADDRESS	PHONE	100%
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 Benefit Representative

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

Notary signature: _____ **Notary Stamp:** _____ **C & B Staff Signature:** _____
Date: _____

Date Notarized: _____