City of Jacksonville

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

ONE CITY. ONE JACKSONVILLE

PART -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					

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 Stamp:

C & B Staff Signature: _____

Notary signature: _____

Date: _____

Date Notarized: _____ _____