



City of Jacksonville

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

ONE CITY. ONE JACKSONVILLE

ACTIVE - FULL TIME EMPLOYEE

SSN: _____

Email Address: _____

Group Life Insurance Beneficiary Form

Date of Birth: _____

Phone Number : _____

EIN _____ Last Name _____ First Name _____ MI _____ Department _____

COJ GROUP LIFE BASIC & SUPPLEMENTAL					Percentage must equal 100%	
1	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	5	6	7
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: _____