



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

ONE CITY. ONE JACKSONVILLE

FORMER APPOINTED OFFICIAL
Group Life Insurance Beneficiary Form

SSN: _____ **Email Address:** _____
Date of Birth: _____ **Phone Number :** _____

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

Note: Former Appointed official must have worked 8 years of continuous service and must be enrolled in Life Insurance prior to termination to continue Life Benefits.
This coverage is only available for 18 months following termination. Life Insurance benefits may revert to 5,000 Supp Life Policy for Retirees ONLY

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%
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	NAME(S)	RELATIONSHIP	BIRTH DATE	ADDRESS	PHONE	%
1						
2						
3						
4						

I understand that a check or money order made payable to Tax Collector for this benefit must be received in the Employee 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 Benefits Representative.

Notary required if you mail this form to the Employee Benefits Office.

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