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

ONE CITY. ONE JACKSONVILLE

FORMER ELECTED OFFICIAL

Group Life Insurance Beneficiary Form

SSN: _____ **Email Address:** _____

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 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 Stamp: **C & B Staff Signature:** _____

Notary signature: _____ **Date:** _____

Date Notarized: _____ _____