**City of Jacksonville**

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 Employee Benefits Office.**

**Notary Stamp:**

**Benefits Staff Signature:** _____

**Notary signature:** _____ **Date:** _____

**Date Notarized:** _____ _____