ONE CITY. ONE JACKSONVILLE

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

RETIRED EMPLOYEE

Group Life Insurance Beneficiary Form

SSN: _____ **Email Address:** _____

Date of Birth: _____ **Phone Number:** _____

EIN	Last Name	First Name	MI	Date Retired	Department

Please make one selection: PLAN: _____ **Plan A $5,000** **Plan B $10,000** **Plan C $15,000**

Note: Plans B & C are available for retirees who were in BU 070 as an active employee and enrolled in supplemental life at the time of retirement.

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: _____ _____