City of Jacksonville Life Insurance Beneficiary Designation

FULL NAME: _____ **EMPLOYEE NUMBER:** _____

PERSONAL EMAIL: _____ **LAST 4 of SS#:** _____

PRIMARY BENEFICIARY(IES)				
NAME	**RELATIONSHIP**	**PHONE NUMBER**	**ADDRESS** (**Street**/Apt#.City,State, Zip)	Percentage (must=100%)
			Street:	
			City, State,Zip:	
			Street:	
			City, State,Zip:	
			Street:	
			City, State,Zip:	
			Street:	
			City, State,Zip:	

CONTINGENT BENEFICIARY(RIES) will only be entitled to receive the death benefit if there are no surviving primary beneficiaries.				
NAME	**RELATIONSHIP**	**PHONE NUMBER**	**ADDRESS** (**Street**/Apt#.City,State, Zip)	Percentage (must=100%)
			Street:	
			City, State,Zip:	
			Street:	
			City, State,Zip:	
			Street:	
			City, State,Zip:	

_____ _____

Employee Signature with a copy of pictute ID **Date Signed**

Benefits Division: City Hall at St. James, Suite 150, Jacksonville, FL 32202
Phone #: (904) 255-5575
Fax #: (904) 255-5565

Notary Stamp, Signature and Date

Notarization is required if this form is mailed to the Benefits Division Office