



BU-11 Full-Time Employee Life Insurance Beneficiary Designation

Employee Name: _____ Employee ID#: _____
 Email Address: _____ Last 4 of SS#: _____

Basic and Supplemental Group Life Insurance and Accidental Death and Dismemberment (AD&D)
 When designating a trust as a beneficiary, it is necessary to attach a copy of the Trust Document to this form.

PRIMARY BENEFICIARY(IES)				
Name	Relationship	Phone Number	Address - (Home/ 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(IES): Will only be entitled to receive the death benefit if there are no surviving primary beneficiaries.				
Name	Relationship	Phone Number	Address - (Home/ Apt#, City, State, Zip)	Percentage (must =100%)
			Street:	
			City, State, Zip:	
			Street:	
			City, State, Zip:	
			Street:	
			City, State, Zip:	

Please DO NOT sign until you are in the presence of Benefits Division Staff Notarization is required if this form is mailed to the Benefits Division Office

Employee Signature with a copy of picture ID _____ Date Signed _____ Notary Stamp, Signature and Date _____

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