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