FULL TIME EMPLOYEE BENEFICIARY DESIGNATION

Employee Name: _____

Employee ID: _____ Last 4 digits of SS#: _____

Basic and Supplemental Group Life Insurance

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%)

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%)

Please DO NOT sign until you are in the presence of Employee Benefits Personnel

_____ _____

Employee Signature with a copy of picture ID Date Signed

_____ _____

Employee Benefits Personnel Signature Date Received

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

Notary Signature and Date Stamp

Employee Benefits Office: City Hall at St. James, 117 West Duval St. , Suite 150, Jacksonville, FL 32202 Phone #: (904) 255-5555 Fax #: (904)255-5565