



Life and Supplemental Life Benefit Election Form

Minnesota Life Insurance Company

SECTION 1: ENROLLMENT APPLICATION (Please print.)

Employer: Florida Community College at Jacksonville
501 W. State Street, Jacksonville, FL, 32202

Contact: **Human Resources Department**
(904)632-3316 or (904)632-3319 or
(904)632-3018

Employee Name: _____

Employee SSN: ____/____/____

Employee Home Address: _____

Home Telephone Number: _____

Current Hire Date: _____

Sex: Male Female

Date of Birth: ____/____/____

Annual Salary: _____

SECTION 2: BENEFIT ELECTION

FCCJ provides your basic life insurance at 100 percent of your annual base salary rounded to the nearest \$1,000.

Supplemental Life Amount

All active full-time employees choose one of the following. The maximum amount for basic and supplemental life benefits is \$350,000 combined.

I do not wish to participate in the supplemental life plan.

I elect **one** times my basic life insurance.

I elect **two** times my basic life insurance.

I elect **three** times my basic life insurance.

Beneficiary Designation

When there is no surviving designated beneficiary, or no one has been named, your plan will default to the standard order of priority. The standard order of priority is: spouse, children, parents, then Estate.

Sequentially (In order named) - Benefits will be paid to your beneficiary. If deceased, benefits will be paid to the first contingent beneficiary. If both are deceased, benefits will be paid to the second contingent beneficiary.

Primary Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

1st Contingent Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

2nd Contingent Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

OVER

Jointly - Benefits shall be divided any payable as indicated below. (Percentages should total 100 percent.)

Primary Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

Primary Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

Primary Beneficiary: Name _____ Relation: _____

Address: _____

Phone: _____ SSN: _____ DOB: _____

READ CAREFULLY:

SECTION 3: ACCEPTANCE AND WAIVER OF COVERAGE(S)

I have been given the opportunity to apply for these benefits. In Section 2 above I have indicated my election. I realize that if I apply for these benefits at a later date, I will be required to furnish evidence of insurability and the insurance company will have the right to refuse my request.

I hereby authorize any deduction from my earnings of the amount (if any) required to cover my contributions.

Employee Signature

Date