

RETIRED _____

ACTIVE _____



Mission Statement: We are committed to the success of every student!

**ALACHUA COUNTY PUBLIC SCHOOLS EMPLOYEE
BENEFICIARY CHANGE FORM FOR
TERM LIFE INSURANCE**

Primary:

(*It is recommended that all beneficiaries be 18 years of age or older)

Name	Date of Birth	Relationship	Telephone Number	Percentage

Contingent:

(In the event your primary beneficiary/ies precede(s) you in death. *It is recommended that all beneficiaries be 18 years of age or older)

Name	Date of Birth	Relationship	Telephone Number	Percentage

Employee Print Name

Employee Signature

Date:

Last four of SS# or EMP#

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me on this ____ day of _____, 20____,
By _____, who is personally known or produced
_____ as identification.

Notary Signature

(NOTARY STAMP OR SEAL)

Printed Name of Notary