



## CITY OF CORAL GABLES

### DESIGNATION OF BENEFICIARY FORM ACCIDENTAL DEATH POLICY (ACCORDING TO FLORIDA STATUTES)

\_\_\_\_\_ New Employee  
\_\_\_\_\_ Change of Beneficiary

EMPLOYEE NAME:

\_\_\_\_\_

DATE OF BIRTH:

SOCIAL SECURITY #:

\_\_\_\_\_

EMPLOYEE #:

OCCUPATION:

\_\_\_\_\_

### BENEFICIARY NOMINATION

**FULL NAME**

**RELATIONSHIP**

**DATE OF BIRTH**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**