Iowa Department of Administrative Services

EMPLOYEE SUPPLEMENTAL LIFE PAYMENT

Department Name: _____ **Date:** _____

Employee Name: _____ **SSN:** _____

Payroll Number: _____

Leave Code: _____

Explanation: _____

_____

Enter only one employee name, plan name, insurance code and dollar amount per request.
All fields on form must be completed or this request may be returned due to insufficient information.
Only fill out this form if an employee has provided a check for their supplemental life insurance.

Amount: $_____

Add Life Supplemental Code: _____

OR

Changing Existing Supplemental Code: From: _____ **To:** _____
(Old Code) **(New Code)**

For Month of: _____

***Please make sure the amount of the check matches the amount on the supplemental life rate sheets.**