Iowa Department of Administrative Services

 **EMPLOYEE SUPPLEMENTAL LIFE PAYMENT**

**Department:**        **Date:**

**Employee Name:**        **SSN:**

**Payroll Number:**

**Leave Code:**

*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:** $      **\*Please make sure the amount of the check matches**

 **the amount on the supplemental life rate sheets.**

**Life Supplemental Code:**

**For Month of:**

CFN 005-02 03/14

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