

**Minnesota Life**  
**Supplemental and Dependent Life Coverage Form**  
**for**  
**Leave Without Pay (LWOP), Family Medical Leave**  
**(FMLA), Workers Compensation or Military Leave**

If you are out on LWOP, FMLA, Workers Compensation, or Military Leave please complete this form and **send to Minnesota Life** in order to continue your Supplemental and any Dependent Life coverage. If premiums are due during your leave, Minnesota Life will bill you directly for the coverage.

Agency Name: \_\_\_\_\_ Agency # \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Type of Leave: \_\_\_\_\_

Estimated Leave Dates: \_\_\_\_\_ to \_\_\_\_\_

Supplement/Dependent Life Insurance premium amount: \$ \_\_\_\_\_  
(**Note:** Please provide a monthly life insurance amount)

**Note:** Some agencies will deduct premium retro-active when you return to work. If applicable, Minnesota Life will refund any excess supplemental/dependent life premium

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed

If you have any questions, please contact Minnesota Life at 1-888- 826-2734.

**Return/mail this form to:**  
**Minnesota Life**  
**Attn: B2-4930**  
**400 Robert Street North**  
**St. Paul, MN 55101**

**PLEASE DO NOT SEND THIS FORM OR FUNDS TO EBD**