Affidavit of Termination of Domestic Partnership

I, _____ declare that I no longer have a
(Employee's Name)

Domestic Partnership with _____.
(Print Former Partner's Name)

I file this Termination of Domestic Partnership to cancel the Affidavit of Domestic Partnership on file with the Insurance & Benefits Office. I understand any insurance provided to my former Partner will be cancelled on the last day of the pay period in which this form is accepted by the Insurance & Benefits Office. I accept that I may not file another Affidavit of Domestic Partnership until twelve (12) months have passed from this same date.

For COBRA notification purposes my former partner's current mailing address is:

_____ Street Address

_____ City, State and Zip

I declare under penalty of perjury that the above statements are true and correct.

_____ _____
Employee Signature Date

_____
Employee's ID Number

Received by: _____ Date _____
(Human Resources Director, or designee)