



Termination of Domestic Partnership

Employee Name (print)

I CERTIFY THAT:

1. I revoke the Affidavit of Domestic Partnership with _____
(Domestic Partner Name) effective the date this form is executed.
2. I understand that I am not eligible to file another Affidavit of Domestic Partnership until six (6) months has passed from the date of this Termination of Domestic Partnership.
3. I have provided this information in this Statement of Termination for the sole purpose of ending the Domestic Partnership benefits.
4. I understand that by filing this Termination of Domestic Partnership my former domestic partner and their legal dependents may no longer be eligible for benefits in which they were formerly enrolled.

Employee Signature: _____

Date: _____