Domestic Partner Termination Form

Employee Name: _____ Employee #: _____

Domestic Partner, as used in this document, shall apply to all Domestic Partners. The Health Insurance Enrollment/Change form is also required to process the termination.

The effective date of the termination of the domestic partnership: _____.

I, (Employee) _____, declare that (Partner) _____ and I are no longer Domestic partners.

Termination of Domestic Partnership is due to:

____ Termination of domestic partnership due to change in one or more circumstances attested to in the Domestic Partner Affidavit form
____ Death of the domestic partner
____ Voluntary termination of coverage of domestic partner due to other insurance coverage
____ Other_____

Employee Signature: _____ Date: _____

HR Representative Signature: _____ Date: _____