TERMINATION OF DOMESTIC PARTNER BENEFITS

- o I (name of employee) _____, affirm that the Affidavit of Domestic partnership attested to and signed by me on (date of Affidavit) _____ shall be and is terminated as of this date, due to:

  - o Termination of domestic partnership because of a change in one or more of the circumstances attested to in Section One of the Affidavit.
  - o Marriage to domestic partner.
  - o Death of domestic partner.

- o I (name of employee) _____, affirm that the Affidavit of Domestic partnership attested to and signed by me on (date of Affidavit) _____ remains in effect, but that I wish to cancel employee benefit coverage on my domestic partner (and his/her children, if applicable), due to:

  - o Other insurance coverage.
  - o Change in personal circumstances.

I understand that I cannot enroll this domestic partner until the next Open Enrollment or when there is a qualified family status change.

_____ _____

Signature of Employee Date

_____ _____

Signature of Witness Date

Employee ID: _____