IOWA
Department of Administrative Services

Domestic Partnership Cancellation of Health and Dental Coverage

I, _____ and _____
(Employee Name) (Print Name of Domestic Partner)

have entered into a domestic partnership.

Covered Dependents resulting from the Domestic Partnership

The following dependent(s) are **enrolled in** the State's health and/or dental insurance as a result of the domestic partnership.

		Health	Dental
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐

Remove Coverage for Dependents

Due to the qualified life event below, I want to **remove** the following dependent(s) from my coverage.

Qualifying Life Event: _____ Event Date: _____

Currently Covered Dependents

		Health	Dental
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐
Dependent Name: _____	Date of Birth: _____	☐	☐

Acknowledgements

- The domestic partnership is still in force.
- I am making this change within 30 days after the date of the event.
- I will only be able to enroll the dependents in insurance coverage at:
  - The annual enrollment and change period or
  - As a result of a qualified life event.
- I will not be charged added value tax for any dependents that are not tax dependents. Further, I understand that if I reenroll dependents, resulting from the domestic partnership, that added value tax may once again apply.

Employee Name (Printed): _____ Last Four Digits of Your Social Security Number: _____

Employee Signature: _____ Signature Date: _____

Please submit completed form to your Human Resources Associate