IOWA
Department of Administrative Services

Domestic Partnership
Cancellation of Health and Dental Coverage

Please note, this form should only be completed due to a qualified life event to remove a Domestic Partner/Domestic Partner child(ren) from existing health and/or dental coverage. To remove a Domestic Partner due to the termination of an established relationship, please submit a Termination of Domestic Partnership Form.

Employee Name:____
(Employee Name Printed)

Domestic Partner Name:____
(Domestic Partner Name Printed)

The following dependent(s) are enrolled in the state's health and/or dental insurance as a result of the Domestic Partnership. Due to the qualified life event below, I want to remove the following dependent(s) from my coverage.

Qualifying Life Event:____ **Event Date:**__________________

Covered Dependents resulting from the Domestic Partnership	Date of Birth	Enrolled in Health	Enrolled in Dental
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Acknowledgment

- The Domestic Partnership is still in force.
- I am making this change within 30 days of the qualified life event.
- I will only be able to re-enroll the dependents in insurance coverage during Open Enrollment or as a result of a new qualified life event.
- If Added Value Tax was applicable, it will be removed the first of the month following the notification in writing to your agency Human Resource Associate.
- A qualified life event will need to be submitted and approved in Workday to complete the change.

Employee Name:____ **Last Four Digits of SSN:** _________
(Employee Name Printed)

Employee Signature:____ **Signature Date:**_______________

Please submit completed form to your Human Resources Associate