Confidential

Department of Administrative Services

Termination of Domestic Partnership

I _____ submit this Termination of Domestic Partnership

(Print Name of Employee)

to cancel the Affidavit of Domestic Partnership previously submitted. The Domestic Partnership between I and

_____ ended on: _____.

(Print Name of Domestic Partner) (*Date of Termination)*

OR

My Domestic Partner,_____ died on:_____.

(Print Name of Domestic Partner) *(Date of Death)*

I understand that coverage for the domestic partner and the domestic partner's children will terminate at the end of the month in which my personnel assistant receives both this termination form and insurance coverage is cancelled in accordance with the department/agency procedures. The completed "Termination of Domestic Partner" form and cancellation of health and/or dental coverage must be signed within 30 days of each other.

I further understand that I have already agreed in the Affidavit of Domestic Partnership previously submitted, that after termination of the Domestic Partnership, another Affidavit of Domestic Partnership cannot be filed with my personnel assistant until twelve months have elapsed, after which I may enroll a new Domestic Partner and his/her eligible dependent children in my health and dental insurance plans subject to the State's eligibility and enrollment rules.

_____

Signature of Employee

_____

Date

_____

Signature of Human Resources Associate

_____

Date Received from Employee