# Domestic Partnership
# Cancellation of Health and Dental Coverage

I, ______________________________ and ______________________________
(Employee Name) (Print Name of Domestic Partner)
have entered into a domestic partnership.

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

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

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 | Remove from Health | Remove from Dental |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

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 SSN: __________

Employee Signature: ______________________________

Signature Date: ______________________________

**Please submit completed form to your Human Resources Associate**