# TERMINATION OF DOMESTIC PARTNERSHIP

*CONFIDENTIAL*

I, _____ , submit this Termination of Domestic Partnership to
(Print or type full name of employee)

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

_____ ended on: _____ .
(Print or type full name of domestic partner) (Print or type date partnership ended)

**OR**

My Domestic Partner _____ died on: _____
(Print or type full name of domestic partner) (date of partners 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 the partnership ends, and University Benefits Office receives this form. The completed "Termination of Domestic Partner" form must be submitted within 30 days following the end of the partnership.

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 University Benefits Office until twelve months have elapsed, after which I may enroll a new domestic partner and their eligible dependent children in my health and dental insurance plans subject to the State's eligibility and enrollment rules.

_____
*Signature of Employee*

_____
*Date*

_____
*University Benefits Office Staff Member*

_____
*Date Received from Employee*

Revised 1.23.25