University
Human Resources
Benefits Office

TERMINATION OF DOMESTIC PARTNERSHIP

CONFIDENTIAL

I (print name of employee/student), ____submit this

Termination of Domestic Partnership to cancel the Affidavit of Domestic Partnership previously submitted.

The domestic partnership between I and (print name of partner) ____ ended

on: ____.

OR

My domestic partner ____________________________________ died on: _______________________________.

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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 the University Benefits Office until 12 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.

Employee/Student University ID:

Signature of Employee/Student: **Date:**

For Office Use Only:

Date Form Was Received:

University Benefits Office Signature: