

Termination of Domestic Partnership

Employee Information			
Employee Legal Name (First, Middle Initial, Last):		Social Security Number:	
Domestic Partner Information			
Domestic Partner Legal Name (First, Middle Initial, Last):		Social Security Number:	
Mailing Address:	City:	State:	Zip Code:
Dependent Information			
Children to be removed from Benefits due to end of Domestic Partnership			
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
Declaration of Termination of Domestic Partnership			
<p>I, _____, file this Termination of Domestic Partnership to revoke the (Print name of Employee) Affidavit of Domestic Partnership previously filed by me.</p> <p>This relationship ended on ____/____/____.</p> <p>I acknowledge that I understand that my former domestic partner and their dependents will no longer be eligible for continued participation in my company's benefit program.</p> <p>In the event that termination of this partnership is not due to the death of my domestic partner, I have mailed a copy of this notice to my former domestic partner.</p> <p>I affirm, under penalty of perjury, that the above statements are true and correct.</p>			
Employee Signature:			Date: