Termination of Domestic Partners

I _____ certify that:
Name of enrollee (please print)

I _____ and _____
Name of enrollee (please print) Name of domestic partner (please print)

have terminated our domestic partnership.

I affirm that the effective date of termination of this domestic partnership is _____.
Date

I affirm that a copy of this termination statement will be provided to my former domestic partner within seven days.

I understand that another Affidavit of Domestic Partnership cannot be filed until six (6) months after this statement of termination of the previous partnership has been filed with my employer's Health Benefits Administrator.

I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements may require payment by myself of claims incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in (disciplinary action by my employer (or) in (other) legal actions appropriate to the prosecution of insurance fraud.

_____ _____
Signature of Enrollee Date

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