Notice of Termination of Domestic Partnership

I, _____, declare that _____ and I no longer qualify as
Employee Name — Name of Former Domestic Partner

domestic partners. Our domestic partnership ended on _____.
Date of Termination

I request to cancel any and all health insurance benefits for my former domestic partner (and his/her dependent children), which I understand will discontinue at the end of the month of when the relationship ended. Further, I certify that I have sent my former domestic partner a copy of this notice via U.S. mail to the following address:

_____ on _____ , _____
Address of Former Domestic Partner — Month and Day — Year

_____ _____ _____
Employee Print Name — Employee Signature — Date

Notary Acknowledgement

State of _____

County of _____

On this _____day of _____, 20_____, before me, a Notary Public, came whose indentity was known or satisfactory proven to me, who, being duly sworn accordingly to law, executed the above Notice of Termination of Domestic Partnership for the purpose recited therin, stating that the representations made therein are true and correct to the best of their knowledge, information and belief.

_____

Notary Public

My Commission Expires: _____