DISSOLUTION OF DOMESTIC PARTNERSHIP & TERMINATION OF COVERAGE FORM

Employee Information:

Name: _____

Employee ID/SSN: _____

Department: _____

Phone/Email: _____

Domestic Partner Information:

Name: _____

Last Known Address: _____

City/State/Zip: _____

SECTION 1 – DISSOLUTION STATEMENT

I hereby certify that I and the above-named domestic partner terminated our domestic partnership as of:

Effective Date: _____

I request termination of health insurance coverage for my former domestic partner under the company/group health plans, effective the date our partnership ended.

SECTION 2 – NOTIFICATION & ACKNOWLEDGEMENTS

- I affirm a copy of this notice will be or has been provided to my former domestic partner within 14 days of this filing.
- I understand that coverage for my former partner and their dependent children (if any) will end as of the date above.

- I understand I may not add another domestic partner, or reenroll the same partner, until length of time required by your plan, e.g., 12 months/one year.
- I understand any false or misleading statements may result in financial responsibility or disciplinary action.
- I understand my former partner may be eligible for COBRA continuation of coverage (if applicable) and that the 60-day COBRA eligibility period starts on the date of dissolution, not the notification date.

Partner's Children to be removed from coverage (if any):

Names: _____

SECTION 3 – SIGNATURE

I affirm that the above information is true to the best of my knowledge and that I am notifying HR/Benefits within the time period required.

Signature: _____ Date: _____

(Sign in the presence of a Notary, if required)

For HR/Benefits Office Use Only:

- Date Received: _____
- Processed By: _____

NOTE:

Submit this completed form to your benefits office. You are responsible for notifying your partner and complying with all timeframes and additional documentation, if applicable.