STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____ and _____

have terminated our domestic partner relationship effective _____.

I understand that health, dental, vision, critical illness and voluntary AD&D coverage for the covered domestic partner named above and their dependent(s) will terminate on the first of the month following the below listed execution date.

I understand that another Affidavit for Enrollment of Domestic Partners cannot be filed until six months from the date of the filing of this statement.

I declare under penalty of perjury that the above statements are true and correct.

_____	_____	_____
Name of Employee	Signature of Employee	Employee ID No.
_____	_____	_____
Name of Domestic Partner	Signature of Domestic Partner	Employee ID No. (If Applicable)

_____
Date of Completion

Please complete and return to Human Resources – Benefits Division DHRBenefits.FGG@sdcounty.ca.gov
Please retain a copy for your records.