

Notice of Dissolution of Domestic Partnership

I, _____ make and file this Notice of Dissolution of Domestic Partnership in order to cancel the previously filed Declaration of Domestic Partnership and declare and acknowledge as follows:

I wish to cancel the Declaration of Domestic Partnership previously filed with respect to

(Name of Partner)

or

The domestic partnership between me and _____ ended on _____
(Name of Partner) (Date)

or

My domestic partner _____ died on _____
(Name of Partner) (Date)

I understand that all benefits afforded to my ex-Domestic Partner and his/her dependent children and contributions for their coverage will cease in accordance with underlying plan provisions, except for the health subsidy, which will terminate based on the provisions of the Health Insurance Premium Reimbursement Program.

I understand that I may not file a new Declaration of Domestic Partnership for a minimum of six (6) months following the date this Notice of Dissolution is received by the Board.

(Employee name)

(Date)

(Signature)

(Employee's Social Security Number)

(Domestic Partner name)

(Domestic Partner's SSN)

(Dependent Name)

(Dependent SSN)

(Dependent Name)

(Dependent SSN)

