Marion County
STATEMENT OF TERMINATION
OF COVERAGE FOR DOMESTIC PARTNER

I (employee) ____, affirm that the Affidavit of Domestic Partnership attested to and signed by me on _______________ (date of original Affidavit of Domestic Partnership) shall be and is terminated as of the below date.

Termination is due to:

☐ Termination of domestic partnership due to change in one or more circumstances attested to in Section One of the Affidavit.

☐ Marriage to domestic partner.

☐ Death of domestic partner.

☐ Voluntary termination of coverage of domestic partner due to other insurance coverage.

I understand that I cannot file a Statement of Domestic Partnership to enroll a new domestic partner until twelve (12) months following the receipt of this statement by my employer.

____ _________________________
Signature of Employee Date

Witness: _____________________________________ _________________________
Signature Date

A Medical & Dental Enrollment/Change form must be submitted with the statement of termination.

Complete & send to Business Services – Risk Management within 31 days of above event