Marion County
STATEMENT OF TERMINATION OF
DOMESTIC PARTNER'S HEALTH COVERAGE

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 II of the Affidavit.
- ☐ Marriage to domestic partner.
  (Please include copy of proof of marriage with enrollment form).
- ☐ Death of domestic partner.
- ☐ Voluntary termination of coverage of domestic partner due to other insurance coverage.

Date of above event: _____

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

A Marion County Health Plans Enrollment/Change Form must be submitted with this Statement of Termination of Domestic Partnership.

Complete & send to Human Resouces - Employee Benefits within 30 days of the above event.