



TERMINATION OF DOMESTIC PARTNERSHIP

Educational Entity _____ Employee ID # or E # _____

I, (*print name of employee*) _____ file this Termination of Domestic Partnership to revoke the Affidavit of Domestic Partnership previously filed by me.

This relationship ended on (MM-DD-YY) _____ .

I understand that:

- I must cancel all OEBB-sponsored insurance coverage for my former domestic partner and/or domestic partner's child(ren).
- I may not file another Affidavit of Domestic Partnership until six (6) months have passed from this date.
- I must attach the OEBB enrollment/change form canceling coverage for ineligible individuals.
- My former domestic partner, who filed the Affidavit of Domestic Partnership with me, may have the option to continue benefit coverage through COBRA regulation and self-payment of premiums.

My former domestic partner's name, current address (if known) and date of birth is:

First, MI, Last Name _____
Current Address _____
Current Address _____
Date of Birth _____

Employee Signature: _____ Date: _____

Educational Entity Use Only:

Received by: _____ Date: _____