



Termination of Domestic Partnership Employee or Participant



SECTION A – EMPLOYEE INFORMATION

Last	First	MI	
Date of Birth (mm-dd-yyyy)	ID Number (SSN, OUS#, Benefit#)		
Residence Address <input type="checkbox"/> New Address	City	State	ZIP
	County	Home Phone	
Mailing Address (if different from above) <input type="checkbox"/> New Address	Agency	Work Phone	
	E-mail		

SECTION B – DOMESTIC PARTNER INFORMATION

Last	First	MI
Date of Birth (mm-dd-yyyy)	ID Number (SSN, OUS#, Benefit#)	
Current Address (if known)		

SECTION C – EMPLOYEE SIGNATURE AND AUTHORIZATION

I _____ (print name) file this Termination of Domestic Partnership form to revoke the Affidavit of Partnership previously filed by me. This relationship ended on _____.

I understand that:

- I must wait six months from this date before I can file another Affidavit of Domestic Partnership.
- I must cancel all PEBB-sponsored insurance coverage for my former domestic partner and/or domestic partner's child(ren). The appropriate PEBB Medical and Dental and/or Life and Disability Update Form canceling coverage for ineligible individuals is attached.
- 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.

Employee/Subscriber Signature _____ Date _____

Received by _____ Date _____

Agency or BHS Representative

Make a copy of this form for your records. Submit the completed form to your agency payroll, personnel or benefits office. Self-pay participants, submit the form to BHS.