PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Termination of a Domestic Partnership by Affidavit

- Office Use Only -

Approved by ___ Date___

Effective Date_____

See the Summary Plan Description for more information: www.oregon.gov/DAS/PEBB/SPD.shtml

Submit completed form to your agency payroll or university benefits office

1. Contact Information

PEBB Benefit Number (P########), Employee ID, University ID

Last Name	First Name	MI	Agency #	Gender
				☐ F ☐ M

PEBB and the plans in which you enroll will send **all** benefit-related correspondence to your contact address.

Contact Address	Apt #	City	State	Zip	County

Residence Zip Code	Work Zip Code	Work E-mail	Personal E-mail (optional)

Date of Birth	Work Phone	Home Phone (optional)
_ _ / _ _ / _ _ _ _	( ) -	( ) -

2. Domestic Partner's Information

Last Name	First Name	MI

Contact Address	Apt #	City	State	Zip	County

Date of Eligibility	Date of Birth
_ _ / _ _ / _ _ _ _	_ _ / _ _ / _ _ _ _

3. Declaration of Termination of Domestic Partnership

I _____ (please print) file this PEBB Termination of Domestic Partnership to revoke the PEBB Affidavit of Domestic Partnership previously filed by me.

This relationship ended on _ _ / _ _ / _ _ _ _

I understand that I must cancel all PEBB-sponsored insurance coverage for my former domestic partner and domestic partner's children.
I have attached the appropriate PEBB Update Forms canceling coverage for ineligible individuals.

_____ _____

Employee Signature Date

Your former domestic partner, who filed the Affidavit of Domestic Partnership with you, may have the option to continue healthcare coverage through COBRA regulations and self-payment of premiums.

Submit completed form to your agency payroll or university benefits office.

Keep a copy of all benefit documents for your records.