



Appendix 55

## TERMINATION OF DOMESTIC PARTNERSHIP

I \_\_\_\_\_ (please print name) file this Termination of Domestic Partnership to revoke the Affidavit of Domestic Partnership previously filed by me. This relationship ended on \_\_\_\_\_. **I understand that I may not file another Affidavit of Domestic Partnership until six (6) months have passed from this date.**

I understand I must cancel all PEBB-sponsored insurance coverage for which my former Domestic Partner and/or Domestic Partner's dependent(s) were enrolled. Attached is the appropriate PEBB Medical and Dental and/or Life and Disability Update Form canceling ineligible individuals and continuing coverage for all eligible dependents.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Agency/University/Self-Pay Group

\_\_\_\_\_  
Date

I understand that my former domestic partner with whom I filed the aforementioned Affidavit of Domestic Partnership may be eligible for continuation of medical insurance benefits under COBRA regulations.

My former domestic partner's name, date of birth, and address is: (required information)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Received by: \_\_\_\_\_  
Agency Representative or BestChoice Administrators

Date: \_\_\_\_\_