MED3000

Notice of Termination of Domestic Partnership

I, ______________________________________, declare that ______________________________________ and I no longer qualify as
Employee Name — Name of Former Domestic Partner

domestic partners. Our domestic partnership ended on __________________________________.
Date of Termination

I request to cancel any and all health insurance benefits for my former domestic partner (and his/her dependent children), which

I understand will discontinue at the end of the month of when the relationship ended. Further, I certify that I have sent my

former domestic partner a copy of this notice via U.S. mail to the following address:

____ on _____________________ , _________________________
Address of Former Domestic Partner — Month and Day — Year

_______________________________________ _______________________________________ ____________________________
Employee Print Name — Employee Signature — Date

Notary Acknowledgement

State of _____________________________

County of __________________________

On this __________________day of ________________________, 20________, before me, a Notary Public, came

whose indentity was known or satisfactory proven to me, who, being duly sworn accordingly to law, executed the above Notice of

Termination of Domestic Partnership for the purpose recited therin, stating that the representations made therein are true and

correct to the best of their knowledge, information and belief.

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Notary Public

My Commission Expires: ___________________