RETURN COMPLETED FORM TO YOUR EMPLOYER

Statement of Termination for Domestic Partner

Enrollee's name ____

Enrollee's address ____

Domestic Partner's name ____

Name(s) of the Domestic Partner's child(ren) ____

Group name ____ Group number ____

This form is to be completed by the Enrollee or by the covered Domestic Partner. It must be signed and filed with the Group within 31 days after a domestic partnership ends.

I ____

Enrollee or Domestic Partner (print)

certify under penalty of perjury, that each and every statement contained in the following Declaration of Fact is true and correct to the best of my knowledge.

Declaration of Fact:

I. The Domestic Partner under this Subscriber's Certificate and/or Dental Plan Description does not/did not qualify as a Domestic Partner as of (date) ____. The date entered is the *first day* that the Domestic Partner ceased/will cease to meet the definition of a Domestic Partner, as stated in Article I of the Domestic Partners Rider.

II. I make and file this Statement of Termination in order to cancel my Domestic Partner Affidavit, previously filed with the Group.

III. I understand that as a result of my filing this Statement of Termination, coverage for the Domestic Partner and his or her child(ren) will terminate on the last day of the month which includes the date provided in paragraph I. above.

IV. I understand that group coverage may continue for the Domestic Partner and his or her child(ren) as stated in the Domestic Partners Rider and in the Subscriber Certificate and/or Dental Plan Description.

V. I understand that coverage for the Domestic Partner will be reinstated retroactively only if the Group receives a new Domestic Partner Affidavit, signed by both partners and properly notarized within 31 days after receiving this Statement of Termination. Otherwise, a subsequent Domestic Partners Affidavit cannot be filed until 12 months after this Statement of Termination is received by the Group, and is subject to standard enrollment guidelines.

VI. If the former partner is not deceased, I have mailed a copy of this notice to him or her at the last known address, which is:

____

Signed ____ **Date**______________________________

Note to Group: Keep a copy of this document for your records. *Forward the original to HealthTrust with the appropriate enrollment form indicating changes.*