Statement of Disenrollment, Death, or Termination of Domestic Partnership

_____, makes and files this Statement of Disenrollment, Death or
(Name of Employee)

Termination of Domestic Partnership in order to cancel the Declaration of Domestic Partnership previously filed.

I wish to cancel, effective immediately, the Declaration of Domestic Partnership previously filed with respect to_____.
(Name of Domestic Partner)

-OR-

The Domestic Partner relationship between me and_____.
(Name of Domestic Partner)
ended on_____.
(Date of Termination)

-OR-

My Domestic Partner,_____, died on_____.
(Name of Domestic Partner) (Date of Death)

For Termination of Group Health Coverage of Domestic Partnership

I understand that, if my Domestic Partner has previously been covered by the District's group health coverage, the effect of filing this Statement of Disenrollment, Death or Termination of Domestic Partnership is that my Domestic Partner, and/or his or her eligible dependent children, if any, will no longer be covered by the District's group health coverage, in accordance with the terms of the underlying plan(s) ("Plan").

I further acknowledge that it is my responsibility to mail a copy of this signed statement to my Domestic Partner/former Domestic Partner, named above.

I affirm that the statements in this Statement are true to the best of my knowledge.

DATED _____

_____
(Signature)

_____
(Name of Employee)

_____
(Address)

_____
(City, State, Zip Code)