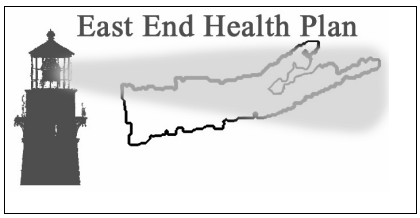

TERMINATION OF DOMESTIC PARTNERSHIP

Note: This form must be completed in full and forwarded to your District's Health Plan Coordinator

SECTION I. DECLARATION

I,_____ certify that:
Employee - Print Name

1) I,_____ and _____
Employee - Print Name Domestic Partner - Print Name
have terminated our domestic partnership.

2) I affirm that the effective date of the termination of this domestic partnership is _____.
Date

3) I affirm that a copy of this termination statement will be provided to my former domestic partner within seven (7) days.

4) I understand that another Declaration of Domestic Partnership Form cannot be filed until two years after the effective date of this Termination of Domestic Partnership Form.

5) I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements may require payment by myself of claims incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of insurance fraud.

Employee's Name	Social Security Number	Sex	Date of Birth
	_____ - ____ - _____		____ / ____ / ___
Employee's Signature :		Date: ____ / ____ / ____	

Return this form in a sealed envelope to the School District's Health Plan Coordinator.