HONORHEALTH

Notice of Termination of Domestic Partner Coverage

1. I _____, certify that I have terminated
   name of employee (please print)

   my Domestic Partnership with _____.
   name of Domestic Partner (please print)

2. I affirm that the effective date of termination of this Domestic Partnership was

   _____.

3. I understand that this Notice of Termination of Domestic Partnership must be filed with the Employee Benefits Department within thirty-one (31) days of the cessation of my Domestic Partner relationship.

4. I affirm that I have provided a copy of this termination notice to my former Domestic Partner.

5. I understand that another Affidavit of Domestic Partnership cannot be filed until twelve (12) months after the Notice of Termination of Domestic Partnership of the previous partnership has been filed with the Employee Benefits Department. The new domestic partnership must have existed for at least twelve (12) months prior to enrolling a new domestic partner.

6. I understand that the effect of filing this Notice of Termination of Domestic Partnership is that my former Domestic Partner will no longer be covered under the medical, dental and/or vision plans. I also understand that no extended benefits, conversion privilege or continuation of coverage will be available to my former domestic partner for any of these benefits after coverage ends.

7. I affirm that assertions in this notice are true to the best of my knowledge and that I may be subject to disciplinary action up to an including termination or dismissal it is determined that the assertions are false.

_____ _____

Signature of Employee Date

Fax to Employee Benefits at (480) 882 5802