Notice of Termination of Domestic Partner Coverage

I _____, certify and declare that _____
(Employee name, please print) *(Former Domestic Partner, please print)*

and I are no longer domestic partners as of _____. I understand that coverage for this individual, my former domestic partner and any covered dependent children of my domestic partner, will terminate at the end of the month of the date of filing this termination with HonorHealth.

1. I make and file this statement of domestic partnership termination in order to cancel the Affidavit of Domestic Partnership filed by me with my former domestic partner.

2. Termination of the Affidavit of domestic partnership is due to the following (check appropriate box):
   - ☐ No longer each other's sole domestic partner.
   - ☐ Death of domestic partner.
   - ☐ Other_____.

3. I understand that this Notice of Termination of Domestic Partnership must be filed with the Employee Benefits Department within thirty (30) 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 Coverage 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 Coverage is that my former domestic partner and applicable dependents 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 some voluntary 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 Employee # Date

Please return this completed form to the Employee Benefits Department using one of the options below.

Fax: 480-882-5802
Email: employee.benefits@honorhealth.com