Domestic Partner Termination Form

Employee Name: _____ Employee ID #: _____

Domestic Partner, as used in this document, shall mean same-sex domestic partner. The Health Insurance Enrollment form is also required to process the termination.

The effective date of the termination of the domestic partnership: _____.

I, (Employee) _____, declare that (Partner) _____ and I are no longer Domestic partners.

Termination of Domestic Partnership is due to:

____ Termination of domestic partnership due to change in one or more circumstances attested to in the Domestic Partner Affidavit form
____ Death of the domestic partner
____ Voluntary termination of coverage of same sex domestic partner due to other insurance coverage
____ Other_____

I understand that I cannot file a Domestic Partner Affidavit form to enroll a new domestic partner for at least twelve (12) months following the receipt of this form by the City of Salem Human Resources department.

Employee Signature: _____ Date: _____

HR Representative Signature: _____ Date: _____