COUNTY OF SANTA CRUZ
STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, ______________________________, previously affirmed to a domestic partner relationship
(Print Name)

with ___________________________ on _____________________________.
(Print Name) **(Date of Affidavit)**

This is to affirm that my domestic partnership with that person is/has been terminated effective on ____.

I affirm under penalty of perjury that the assertions in this Statement of Termination of Domestic Partnership are true and correct to the best f my knowledge.

____ _________________________
Signature of Employee Date

Forwarding Address of Domestic Partner

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IMPORTANT:

1. Dental and vision coverage for the domestic partner and any children of the domestic partner ceases on the last day of the pay period in which the domestic partnership was terminated.
2. For individuals enrolled in the Operating Engineers Health & Welfare Trust plan, medical coverage for the domestic partner and any children of the domestic partner ceases on the last day of the pay period in which the domestic partnership was terminated. For individuals enrolled in any of the other medical plans, medical coverage for the domestic partner and any children of the domestic partner ceases the last day of the month in which the domestic partnership was terminated.

Original: Personnel Department – Employee Benefits Section

Copy: Employee
Copy: Domestic Partner

Date Sent to Domestic Partner ______________________________________

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