

BENTON COUNTY
STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____ affirm that the Affidavit of Domestic Partnership attested to and
(EMPLOYEE NAME)
signed by me on _____ shall be and is terminated as of this date.
(DATE OF AFFIDAVIT)

Termination is due to:

- 1. Termination of domestic partnership because of a change in one or more of the circumstances attested to in Section One of the Affidavit.

- 2. Death of domestic partner.

Employee: I understand that I cannot file an Affidavit of Domestic Partnership to enroll a new domestic partner until six (6) months following the receipt of this Statement by my employer.

Former Domestic Partner (if termination is due to #1 above): I will provide a forwarding address to allow for timely receipt of information relative to continuation of medical and/or dental insurance coverage, and I understand that it is my responsibility alone to advise Benton County immediately of any change in addresses to insure proper notification of health benefits continuation rights.

Name of Employee

Name of former Domestic Partner

Signature of Employee

Signature of former Domestic Partner

Date

Date

Forwarding Address for former Domestic Partner:

RECEIVED BY: _____
EMPLOYEE REPRESENTATIVE

DATE