Washington Counties Insurance Fund

Declaration of Termination of Domestic Partnership

SECTION I

I, _____ declare that, as of ____ / ____ / ____ , I am no longer
Name of Employee (Print) Month Day Year

in a domestic partnership with _____ because:
Name of Domestic Partner (Print)

- ☐ our domestic partnership no longer meets all the status criteria set forth in our Declaration of Domestic Partnership.
- ☐ the domestic partner deceased as of ____ / ____ / ____ (Month Day Year)
- ☐ the domestic partnership dissolved as of ____ / ____ / ____ (Month Day Year)

SECTION II

I understand that termination of coverage of the domestic partner and the domestic partner's dependent children, if any, will be effective upon receipt of this Declaration.

I affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____ ____ / ____ / ____
Employee Signature (Month Day Year)
(or Former Domestic Partner's Signature)

_____

_____

_____
Employee Address

_____

_____

_____
Former Domestic Partner's Address