S.C. Department of Human Resources, Personnel and Civil Service
Employee Benefits Unit
P. O. Box 6100, Veterans Memorial Highway
Bldg. #158, William J. Lindsay County Center
Hauppauge, NY 11788-0099
e-mail address: ebu@suffolkcountyny.gov
631-853-4866

TERMINATION OF DOMESTIC PARTNERSHIP OF ENROLLEES OF ANY OF THE SUFFOLK COUNTY PROVIDED HEALTH PLANS

STATE OF: _____)
)ss.:
COUNTY OF: _____)

I, _____ certify that:
(Name of Enrollee – Please Print)

1. I, _____, and _____
Name of Enrollee (Please Print) Name of Domestic Partner (Please Print)
have terminated our domestic partnership.

2. I affirm that the effective date of termination of this domestic partnership is:
_____.
Date

3. I affirm that a copy of this termination statement has been or will be provided to my former domestic partner within seven (7) days.

4. I understand that another Application for Benefits for a Domestic Partner cannot be filed by me until one year after this statement of termination of the previous partnership has been filed with the Suffolk County Department of Civil Service/Human Resources, Employee Benefits Unit.

5. I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements or failure to provide timely notification of the termination of the partnership may require payment by myself of claim amounts incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of fraud.

Signature of Enrollee (in presence of notary): _____

Social Security Number: _____

Date: _____

Sworn to before me this _____ day of _____, 20__

_____
(Notary Public)