

## NOTICE OF CHANGE IN DOMESTIC PARTNERSHIP

I, \_\_\_\_\_, certify and declare that:  
(Employee—print name)

\_\_\_\_\_ and I are no longer domestic partners as of \_\_\_\_\_.  
(Domestic Partner—print name) (Date)

I understand that health insurance coverage for this individual and his/her covered children under EAB healthcare programs will terminate as of \_\_\_\_\_

The Affidavit of Domestic Partner attested to and filed by me with EAB shall be and is terminated as of this date; and

The termination of the Affidavit of Domestic Partnership is a result of either termination of the partnership or death of the partner; and

In the event that termination of this relationship is not due to the death of my domestic partner, I have mailed a copy of this notice to my former domestic partner at:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(former domestic partner's address)

I affirm, under penalty of perjury, that the above statements are true and correct.

\_\_\_\_\_  
(Employee's Signature)

\_\_\_\_\_  
(Date)

Sworn to me this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public