COUNTY OF SANTA CRUZ

PERSONNEL DEPARTMENT

AJITA PATEL, DIRECTOR

701 OCEAN STREET, SUITE 510, SANTA CRUZ, CA 95060-4073

PHONE: (831) 454-2600 FAX: (831) 454-2411 TDD: 711

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, previously affirmed to a Domestic Partner Relationship

(Name of Employee – please print)

with _____.

(Domestic Partner – please print)

I attest this Domestic Partnership terminated on _____/_____/_____.

(mm) (dd) (yyyy)

I understand that Medical, Dental, Vision and Life Insurance coverage for the Domestic Partner and their dependent(s) cease on the last day of the month in which the Domestic Partner Relationship was terminated.

I also understand that the Domestic Partner that has been removed from my insurance(s) may be eligible for COBRA.

Their mailing address is:_____

_____

I attest under penalty of perjury that the assertions in this Statement of Termination of Domestic Partnership are true and correct.

_____ _____

Employee Signature *Today's date*