COUNTY OF SANTA CRUZ
PERSONNEL DEPARTMENT
AJITA PATEL, DIRECTOR
701 OCEAN STREET, SUITE 510, SANTA CRUZ, CA 95060-4073
(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 _____.
(Name of Domestic Partner – please print)

This affirms that my Domestic Partnership Relationship with _____
(Name of Domestic Partner – please print)

terminated on _____/_____/_____ _____.
(M M) (D D) (Y Y Y Y)

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

_____ _____
(*Employee Signature)* (*Date mm/dd/yyyy)*

Please note:

Medical, Dental, Vision and Life Insurance coverage for the domestic partner and his or her dependent(s), ceases on the last day of the month in which the domestic partnership was terminated.

Domestic Partners that have been removed from your insurance(s) are eligible for COBRA, Continuation of Coverage for 36 months. For COBRA eligibility, please provide their forwarding address:

_____

_____

☐ I do not have his/her forwarding address.