

AFFIDAVIT OF DISSOLUTION OF DOMESTIC PARTNERSHIP

Employee Information

Employee Name (Last, First, Middle)			
Date of Birth	Gender (circle one) M F	Social Security Number	
Address		City	State Zip Code

Domestic Partner Information

Name (Last, First, Middle)			
Date of Birth	Gender (circle one) M F	Social Security Number	
Address		City	State Zip Code

Domestic Partner Dependent Child(ren) Information (List the domestic partner's unmarried biological or adopted child(ren) who are currently enrolled.

Dependent Child Name (Last, First, Middle)	Social Security Number	Date of Birth	RC*	Full-time Student Y / N

RC* (Relationship Code): **DS= biological or adopted son of domestic partner**
 DD=biological or adopted daughter of domestic partner

CERTIFICATION

This certifies that as of _____ (date) my domestic partnership with the above person has terminated. I understand that to register another domestic partnership and enroll that partner in State of Maryland sponsored benefits I must wait 12 months from the date listed above.

I further understand that the domestic partner's eligibility for the State of Maryland sponsored benefits ends on the date the domestic partnership terminates. Failure to notify the State of Maryland within 60 days of the termination date may result in my responsibility to refund the State for benefits paid for ineligible individuals. Continuation coverage similar to COBRA may be elected by the partner and/or the domestic partners covered children within 60 days of the termination of the domestic partner's health care coverage.

At least one of the following documents* must be attached to this affidavit as proof of the dissolution of the domestic partnership:

- Copy of lease or deed for either the Employee's/Retiree's or former domestic partner's new residence that does not list the domestic partner or Employee/Retiree as co-tenant or co-owner;
- Copy of change of address card for driver's license for either the Employee's/Retiree's or former domestic partner;
- Documents establishing the termination of joint ownership of assets/vehicles/investments that had been used to establish financial interdependence; or
- New designation of beneficiary under a life insurance policy, retirement benefits, will or power of attorney that removes the domestic partner.

* Other documents may be accepted. Contact the Employee Benefits Division for more information.

I solemnly affirm under the penalties of perjury under applicable state laws, that the foregoing is true and accurate. I understand that willful falsification of information contained in this Affidavit can result in referral of the matter for investigation and prosecution, the termination of enrollment and coverage of the domestic partner, and the termination of coverage for the employee/retiree. I understand that a civil action may be brought against me for any losses, including reasonable attorney fees, because of a false statement contained in this affidavit. In addition, where permissible, employment related action may be taken against an active employee.

Employee Signature _____ Date _____