Dissolution of Domestic Partnership

Employee/Retiree Name			
Date of Birth	Gender	Social Security Number	
Street Address	City	State	Zip

Former Domestic Partner Name			
Date of Birth	Gender	Social Security Number	
Street Address	City	State	Zip

Children of Former Domestic Partner

Dependent Name	Social Security Number	Date of Birth

CERTIFICATION

This certifies that as of _____ (date) my domestic partnership with the above person has terminated.

I understand that my former domestic partner's (and his/her children, if applicable) eligibility for the State of Maryland sponsored benefits ends on the date our domestic partnership terminated. Failure to notify the state within 60 days of the termination date may result in my responsibility to refund the State for benefits paid for the ineligible individual(s). Continuation coverage similar to COBRA will be offered to my former domestic partner (and his/her child(ren), if applicable).

I further understand that in order to register another domestic partnership and enroll that partner in State of Maryland sponsored benefits I must wait twelve (12) months from the date shown.

At least one of the following documents must be attached to this form 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 other person as co-tenant or co-owner.
- Copy of driver's license change of address card for either party.
- Documents establishing the termination of joint ownership of assets/vehicles/investments that had previously been used to establish financial interdependence.
- New designation of beneficiary under a life insurance policy, retirement benefits, will or power of attorney that removes your former domestic partner.

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

Employee/Retiree Signature _____ Date _____