Affidavit of Domestic Partnership Termination

I ____ certify that I previously filed the appropriate Affidavit with
Franklin County Employee Name (Print)

the Franklin County Benefits Office to establish a domestic partnership, and I now inform the County that

____ is no longer my domestic partner as of
Name of former Domestic Partner (Print)

__________________.
Date

I understand that my former domestic partner is no longer eligible for benefits provided by Franklin County as of the date identified above as the date our domestic partnership ended.

I also certify that I will provide my former domestic partner with a copy of this Affidavit at the following address:

____
Name of former Domestic Partner (Print)

____
Street Address

____
City State Zip Code

Note: If applicable, Franklin County will use this address to mail Health Plan Continuation of Coverage information to your former domestic partner, unless another address is provided.

I understand that another Affidavit of Domestic Partnership to establish a new domestic partnership cannot be filed until six (6) months after this domestic partnership has been terminated. I understand this form may be supplied to my agency's Human Resources Department.

______________________ ______________ ______________
Signature of Employee Date of Birth Date

Employee's Social Security Number (required): Agency: ______________

______________________________ ______________
Signature of Benefits Office Date

Please return form(s) to:
Franklin County Benefits Office
373 S. High Street, 25th Floor
Columbus, Ohio 43215
Phone: 614.525.5750
Fax: 614.525.5515
E-mail: benefits@franklincountyohio.gov
Website: http://BeWell@FranklinCountyOhio.gov