



## Affidavit of Domestic Partnership Termination

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

the Franklin County Benefits & Wellness 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 and my former domestic partner's child(ren), if applicable, are no longer eligible for benefits provided by the Franklin County Cooperative Health Improvement Program 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, the Franklin County Benefits & Wellness Office 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 & Wellness Representative Date

### Please return form(s) to:

Franklin County Benefits & Wellness Office  
373 S. High Street, 25<sup>th</sup> Floor, Columbus, Ohio 43215  
Phone: 614.525.5750 Fax: 614.525.5515  
E-mail: [benefits@franklincountyohio.gov](mailto:benefits@franklincountyohio.gov)  
Website: <http://BeWell.FranklinCountyOhio.gov>