

Affidavit of Domestic Partnership Termination

| 1 | certify th | at I previously filed the a | ppropriate Affidavit with |
|---|---------------------------------------|-----------------------------|---------------------------|
| Franklin County Employee Name (Print) | • | | |
| the Franklin County Benefits & Wellness Office to establish a | domestic partnership | o, and I now inform the C | ounty that |
| Name of former Domestic Partner (Print) | is no lor | nger my domestic partne | r as of |
| Date | | | |
| I understand that my former domestic partner and my former provided by the Franklin County Cooperative Health Improvements partnership ended. | | | |
| I also certify that I will provide my former domestic partner wi | th a copy of this Affida | avit at the following addre | ess: |
| Name of for | mer Domestic Partner (Prin | t) | |
| | | | |
| | Street Address | | |
| | | | |
| City | State | Zip Code | |
| Note : If applicable, the Franklin County Benefits & Velan Continuation of Coverage information to your forwided. | | | |
| I understand that another Affidavit of Domestic Partnership tafter this domestic partnership has been terminated. I un 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, 25th Floor, Columbus, Ohio 43215 Phone: 614.525.5750 Fax: 614.525.5515 E-mail: benefits@franklincountyohio.gov Website: http://BeWell.FranklinCountyOhio.gov