



Finance Department

David N. Cicilline, Mayor | Bruce T. Miller, Finance Director

**NOTIFICATION TO OFFICE OF EMPLOYEE BENEFITS
OF TERMINATION OF DOMESTIC PARTNERSHIP
Form C**

_____ certify that I was no longer in a domestic
(employee name – please print)
partnership with _____ as of _____.
(former domestic partner– please print) (date)

I declare that I will mail a copy of this Notification to my former domestic partnership at:

(former domestic partner’s current address)

as soon as I receive a signed and accepted copy of this Notification back from the Medical Benefit Plan Administrator. I declare under penalty of perjury that the above statements are true and correct. I understand that my former domestic partner is only eligible for health benefits under my health insurance coverage with the City if a family court order of divorce provides that such coverage shall continue. (Even with such a court order, I understand that such coverage will terminate upon the earlier of (i) the remarriage of either party and/or (ii) when a former spouse becomes eligible to participate in a comparable plan through his or her own employment). If I am requesting that coverage for my former common-law spouse continue, I have submitted a copy of the court order with this Notification.

Employee’s signature Date Employee’s social security number

Employee’s address and telephone number: _____

Agency: _____

Accepted by:

Medical Plan Benefits Administrator Date