



Washington Counties Insurance Fund
Declaration of Termination of Domestic Partnership

SECTION I

I, \_\_\_\_\_ declare that, as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_, I am no longer
Name of Employee (Print) Month Day Year
in a domestic partnership with \_\_\_\_\_ because:
Name of Domestic Partner (Print)

- our domestic partnership no longer meets all the status criteria set forth in our Declaration of Domestic Partnership.
domestic partner is deceased as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_
Month Day Year
the registered domestic partnership dissolved as of \_\_\_\_ / \_\_\_\_ / \_\_\_\_
(Please attach documentation) Month Day Year
\_\_\_\_\_

SECTION II

I understand that termination of coverage of the domestic partner and the domestic partner's dependent children, if any, will be effective upon receipt of this Declaration.

I affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
Employee Signature Month Day Year
(or Former Domestic Partner's Signature)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Employee Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Former Domestic Partner's Address