



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.
- the domestic partner deceased as of _____ / _____ / _____
Month Day Year
- the domestic partnership dissolved as of _____ / _____ / _____
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
(or Former Domestic Partner's Signature)

_____/_____/_____
Month Day Year

Employee Address

Former Domestic Partner's Address