HealthTrust

STATEMENT OF TERMINATION FOR DOMESTIC PARTNER

Enrollee Name: _____ **Date:** _____

Enrollee Mailing Address: _____ **Enrollee Date of Birth:** _____

Group Name: _____

Former Domestic Partner Name: _____

Former Domestic Partner Mailing Address: _____

Name(s) of the Domestic Partner child(ren): _____

This form must be completed and signed by the Enrollee as notification of a Termination of Domestic Partnership. It must be filed with the Group within 31 days after a domestic partnership terminates.

I, _____

Enrollee (printed name)

certify under penalty of perjury, that each and every statement contained in the following Declaration of Fact is true and correct to the best of my knowledge.

Declaration of Fact:

1. The Domestic Partner under this Subscriber's Certificate and/or Dental Plan Description does not/ did not qualify as a DomesticPartner as of (date) _____ . The date entered is the *first day* that the DomesticPartner ceased/will cease to meet the definition of a Domestic Partner, as stated in Article I of the Domestic Partners Rider.
2. I make and file this Statement of Termination in order to cancel my Domestic Partner Affidavit, previously filed with the Group.
3. I understand that as a result of my filing this Statement of Termination, coverage for the Domestic Partner and his or herchild(ren) will terminate on the last day of the month which includes the date provided in paragraph I above.
4. I understand that group coverage may continue for the Domestic Partner and his or her child(ren) as stated in theDomestic Partners Rider and in the Subscriber Certificate and/or Dental Plan Description.
5. I understand that coverage for the Domestic Partner will be reinstated retroactively only if the Group receives a new DomesticPartner Affidavit, signed by both partners and properly notarized within 31 days after receiving this Statement of Termination.Otherwise, a subsequent Domestic Partners Affidavit cannot be filed until 12 months after this Statement of Termination isreceived by the Group, and is subject to standard enrollment guidelines.
6. If the former partner is not deceased, I have mailed a copy of this notice to him or her at the last known address as stated above.

_____

Enrollee Signature **Date**

Note to Group: Keep a copy of this document for your records. *Please forward a copy to HealthTrust along with the Medical and/or Dental Application and Change form indicating changes.*