

Termination Statement of Domestic Partnership

(Please print or type)

Effective	, I,			am no longer entered into
Effective(dat	re)	(employee)	
a domestic partner	rship with			as defined
	_		(domestic partner)	
by the Affidavit o	f Domestic Part	nership condition	ons that I previously	signed and dated.
Employee Informat	ion			
Name:				_
Work Phone:		Hom	e/Cell Phone:	
Domestic Partner I	nformation			
Name:				-
Street Address:				
City:		State:	Zip Code:	
Notification				
	ermination of c			partner, I will notify my former ermination Statement within 31 days
Acknowledgement				
partnership, the healt Pinellas County Unit the end of the pay pe	th and/or dental fied Personnel S riod in which th	plan coverage of System as well a ne domestic part	of my domestic partness any dependents of the contraction is terminated.	oon the termination of our domestic er who is not an employee in the such domestic partner, shall cease at d. I understand that another Affidavit bmission date below.
Employee Signature				Date
Submission				

Return the completed form to Employee Benefits within 31 days of the ending of the domestic partner relationship. The termination of coverage will change your premium deduction based on your new coverage level. Submit by mail to Employee Benefits, Human Resources, Annex, 400 S. Ft. Harrison Ave., Clearwater, FL 33756, by email at employee.benefits@pinellas.gov, or by fax to (727) 453-3573. Questions? Call Benefits at (727) 464-3367, opt. 1.

Pinellas County reserves the right to modify, amend or terminate any or all of the provisions of this domestic partner policy and these administrative procedures at any time for any reason upon appropriate action by Pinellas County. Notwithstanding any of the prior statements, in all cases Pinellas County policies will govern.