FCSRMC
FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP

I,_____, make and submit to the Group
(Subscriber Name)

this Affidavit of Termination of Domestic Partnership in order to cancel the Affidavit of Domestic Partnership previously filed. The Domestic Partnership between me and

_____, ended on _____
(Name of Domestic Partner) (Date of Termination)

OR

My Domestic Partner_____, ended on _____
(Name of Domestic Partner) (Date of Death)

If applicable, the Domestic Partner's covered dependent child(ren) are:

Last Name	First Name	MI
Last Name	First Name	MI
Last Name	First Name	MI
Last Name	First Name	MI

I understand that, if my Domestic Partner and if applicable, his/her dependent child(ren), has previously been covered by the Group's health plan, the effect of filing this Affidavit of Termination of Domestic Partnership is that my Domestic Partner and if applicable, his/her dependent child(ren) will no longer be covered by the Group's health plan.

I further acknowledge that it is my responsibility to mail a copy of this signed Affidavit of Termination of Domestic Partnership to my former Domestic Partner, named above.

Signature of Subscriber _____ Date _____

Address _____

Signature of Notary Public _____ Date _____

(Seal)