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)

I understand that, if my Domestic Partner, 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 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)