COLORADOSCHOOLOFMINES

EARTH ● ENERGY ● ENVIRONMENT

Statement of Termination Of Domestic Partnership

I, ____ ________________________________
(Name of Employee – Print) Employee ID Number (required)

certify that I previously filed the appropriate Affidavit of Domestic Partnership with the Office of Human Resources to establish a domestic partnership, and I now inform the Office of Human Resources that:

______________________________ **is no longer my domestic partner as of** _________________
(Name of former Domestic Partner – Print) (Date of Termination)

I understand that the domestic partner identified above is no longer eligible for the following programs:

- Group Health Benefits (medical, dental, and voluntary vision care plans)
- Group Term Life Insurance
- Group Accidental Death and Dismemberment Insurance

I certify that in addition to this Statement, I am submitting to the Office of Human Resources the necessary forms for the purpose of canceling any benefits plan coverage(s) in which my former domestic partner was enrolled.

I also certify that I will provide my former domestic partner within ten (10) days of completing this Statement with a copy of this Statement at the following address (please print):

____
Former Domestic Partner's Name

____
Street Address

____
City State Zip Code

*(The Office of Human Resources will use **this address** to mail Health Plan Continuation of Coverage information to your former domestic partner, unless another address is provided.)*

I understand that another Affidavit of Domestic Partnership may not be filed to establish a new domestic partnership until twelve (12) months after this domestic partnership has been terminated as identified above.

____ ________________________
Signature of Employee Date Signed

Rev. 9-29-08