



Affidavit of Termination of Domestic Partnership

I, _____, an employee of Banner Health, submit this affidavit of Termination of Domestic Partnership.

This form cancels the previously submitted Affidavit of Domestic Partnership.

The Domestic Partnership between _____, my Domestic Partner, and I ended on _____ (date).

OR

My Domestic Partner, _____, passed away on _____ (date).

I understand that this Affidavit of Termination of Domestic Partnership initiates **no change to my actual insurance coverage**. I must complete a Qualifying Life Event, Divorce/Remove Domestic Partner or Death of Dependent, and **actively remove my former Domestic Partner from benefit coverage within 31 days** of the dissolution of the Domestic Partnership. I am responsible for payment of Domestic Partner benefit premiums through the end of the month the Domestic Partnership ended.

I further understand that after termination of this Domestic Partnership, **another Affidavit of Domestic Partnership cannot be filed until 12 months have elapsed** (as the Domestic Partner Affidavit states), after which I may enroll a new Domestic Partner in my health and dental care programs, subject to Banner Health's eligibility and enrollment rules.

Printed Name: _____

Signature: _____

Employee ID#: _____ Date: _____