Affidavit of Termination of Domestic Partnership

❶ DECLARATION:

WE EACH SEPARATELY DECLARE, UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE STATEMENTS BELOW ARE TRUE AND CORRECT.

That the partnership between:

and

EMPLOYEE (print or type name) | DOMESTIC PARTNER (print or type name)

terminated on this date_____.
(date of domestic partnership termination)

We understand that it is our responsibility to notify the MBC HR Employee Benefits Help Desk within 30 days of the domestic partnership ending, and that domestic partner (and children) healthcare coverage will end on the last day of the month in which the domestic partnership ends. The domestic partner (and children) will be eligible for up to 36 months of extended medical, dental and/or voluntary vision coverage on a self-pay basis through COBRA if: (1) They are covered under these plans on the date the domestic partnership ended, and (2) The MBC HR Employee Benefits Help Desk receives this completed form within 60 days of the last day of the month in which the domestic partnership/healthcare coverage ends. For example, if the domestic partnership ends on Oct. 15, healthcare coverage would end Oct. 31 and you would have 60 days (until Dec. 31) to return this form to the MBC HR Employee Benefits Help Desk for your domestic partner to be eligible for COBRA. If the MBC HR Employee Benefits Help Desk does not receive this completed form within those 60 days, COBRA coverage will not be available, and any premiums paid while the domestic partner (and/or children) were not eligible for coverage will not be reimbursed.

EMPLOYEE:

at

Signed on (date) | (City and state where signed)

✍

Employee Signature | Print or type name and employee ID number

DOMESTIC PARTNER:

at

Signed on (date) | (City and state where signed)

✍

Domestic Partner Signature | Print or type name

More on back ➔

❷ UPDATE ADDRESSES:

Employee's new address:

Domestic partner's new address (for COBRA notices):

❸ RETURN THE COMPLETED FORM ANY OF THE FOLLOWING WAYS:

Web:	Cedars-Sinai.MyBenefitChoice.com Log in > Get Answers > Upload Documents You can upload the following types of files: pdf, .jpg, .png, .bmp, .gif, .doc, or .docx
Fax:	206-299-3158
Email:	hwformsprocessing@milliman.com
Mail:	Cedars-Sinai HR Benefits Department c/o MBC HR Employee Benefits Help Desk PO Box 600610 Dallas, TX 75360-0610