Termination of Domestic Partnership Form

2550 Denali St, STE 1614, Anchorage, AK 99503
Office (907) 274-7526 • Fax (907) 222-2556

Member's Name:	**Member ID Number:**
Partner's Name:	
Partner's Dependent Child(ren):	

Certification:
This certifies that as of ___________________(date) my domestic partnership with the above named person has terminated. I understand that to register another domestic partnership I must wait twelve months from the date listed above.

I understand that health coverage for my partner and his/her dependent children will terminate as of the date listed above.

In the event that termination of this partnership is not due to the death of my domestic partner, I have mailed a copy of this notice to my former domestic partner at:

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(Former domestic partner's address)

Failure to notify the Public Education Health Trust within 60 days of the termination date may result in a liability for benefits paid for ineligible individuals. Failure to provide timely notice jeopardizes COBRA health care continuation benefit coverage.

I affirm, under penalty of perjury, that the above statements are true and correct.

______________________________ ____________________
Signature Date