

Affidavit of Termination of Domestic Partnership

Employee Name: _____ **Employee ID# :** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Name of Former Domestic Partner: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security Number: _____

CERTIFICATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I certify that I previously filed an “*Affidavit of Domestic Partnership*” with the above named individual and that effective _____ this domestic partnership has been terminated. I understand that the individual identified above and his/her dependent children are no longer eligible for healthcare coverage. I also understand that I am may no longer apply for accumulated sick leave and/or FMLA leave to care for this individual and/or his/her dependents. I understand that this “*Affidavit of Termination of Domestic Partnership*” will be filed with the Office of Human Resources and that a copy will be mailed to the former domestic partner named above.

Employee Signature

Date

Return form to: Office of Human Resources, Jones Hall, One University Plaza, Youngstown, OH 44555