TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN
2701 Whitney Place #100
Forestville, Maryland 20747
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TERMINATION OF AFFIDAVIT OF DOMESTIC PARTNERSHIP

I, _____, hereby declare and acknowledge the following:

I am requesting the removal of my Domestic Partner _____, and his/her eligible dependent children from my medical coverage, effective _____/_____/_____.

OR

Please be advised that the Domestic Partnership between me and _____ ended on ___/____/_____.

OR

My Domestic Partner, _____, passed away on ____/____/_____.

I understand that I will not be eligible to submit a new Affidavit of Domestic Partnership for a period of one (1) year from the date of signing this Affidavit of Termination of Domestic Partnership.

I declare that the statements made in this Affidavit are true and correct to the best of my knowledge.

_____
Employee Name (Printed)

_____
Domestic Partner's Name (Printed)

_____ _____
Employee Signature Date