Affirmation of Termination of Same Sex Domestic Partnership

I, _____, submit this Affirmation of Termination of Same Sex
(Name of Employee)
Domestic Partnership in order to cancel the Affirmation of Same Sex Domestic Partnership previously filed. I declare and acknowledge that I wish to cancel the Affirmation for the following reason:

The Relationship between _____ and me ended on _____ .
(Name of Domestic Partner) *(Date)*

My same sex domestic partner _____ died on _____ .
(Name of Domestic Partner) *(Date)*

I understand that the effect of filing this Affirmation of Termination of Same Sex Domestic Partnership is that my Same Sex Domestic Partner and his or her children will no longer be covered under The University of Akron's Benefits Program.

I understand that I must wait twelve (12) months before I am eligible to cover a new same sex domestic partner or his or her children under The University of Akron's Benefits Program.

Furthermore, if I had declared my Same Sex Domestic Partner or his or her children as my tax dependent, I understand that I may be liable for taxes due to terminating this coverage.

In the event that termination of this relationship is not due to the death of my Same Sex Domestic Partner, I will mail my former Same Sex Domestic Partner a copy of this notice within thirty (30) days at the following address:

_____
(Address)
_____

_____
I affirm that the assertions in this Affirmation are true to the best of my knowledge.

_____	_____	_____
Signature of Employee	Last Four Digits of Social Security Number	Date