Transit Employees'
HEALTH AND WELFARE PLAN
2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747-3457
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# Affidavit of Termination of Domestic Partnership

I, _____ declare and acknowledge as follows:
Name of Employee

I request the removal of my Domestic Partner, _____
Name of Domestic Partner

and his/her eligible dependent children from my medical coverage effective on

_____.
Date

**OR**

Please be advised that the Domestic Partnership between me.

and_____, ended on _____
Name of Domestic Partner Date

**OR**

My Domestic Partner, _____, died on
Name of Domestic Partner

_____.
Date

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

I declare that the statements in this Affidavit are accurate to the best of my knowledge and belief.

By: _____ _____
Signature of Employee/Subscriber Date

cc: _____
Domestic Partner

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