

Domestic Partner Dissolution

Employee Name _____

Employing Agency/Branch _____

Employee ID# _____

This form must be attached to a State of Montana Employee Group Benefits Plan Enrollment/Change Form and is to be used to remove an enrolled Domestic Partner from health care benefits coverage. Coverage ends at 11:59pm the last day of the month in which the dissolution is signed and notarized below.

Partner's Name _____

Dependent's Name(s) _____; _____; _____

Notification of Change in or Termination of Relationship

We, the undersigned, attest that our domestic partner relationship no longer exists.

Employee Signature

Date

Partner Signature

Date

NOTARY PUBLIC

SEAL

Date Commission Expires

Note: Payments for coverage of domestic partners and associated dependents of the domestic partner will continue to be charged to the employee or retiree (or automatically deducted from the employee's paycheck) until the Domestic Partner Dissolution form and State of Montana Employee Group Benefits Plan Enrollment/Change Form are received by Health Care and Benefits Division, PO Box 200130, Helena, MT 59620-0130.