Contra Costa County

Human Resources Department

Employee Benefits Unit
Administration Building
1025 Escobar Street, 2nd FL
Martinez, CA 94553
(925) 655-2100

NOTICE OF TERMINATION OF DOMESTIC PARTNERSHIP

(This form is not for termination of State Registered Domestic Partnerships)

I, _____, (please print name) file this Notice of Termination of Domestic Partnership to revoke the Affidavit of Domestic Partnership previously filed by me. This relationship ended on _____. I understand that I may not file another Affidavit of Domestic Partnership until six (6) months have passed from the date this signed form is received by the Employee Benefits Service Unit.

I understand I must cancel all Contra Costa County-sponsored insurance coverage for which my former Domestic Partner and/or Domestic Partner's dependent(s) were e

enrolled within 30 days from the date I signed this form in Employee Self Service.

_____ _____ _____

Employee Signature Employee I.D. Date

I understand that my former domestic partner with whom I filed the aforementioned Affidavit of Domestic Partnership may be eligible for continuation of medical insurance benefits under COBRA regulations.

My former domestic partner's name, date of birth and address is: (required information)

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