State of Colorado

Termination of Same-Gender Domestic Partnership Affidavit

INSTRUCTIONS

1. Following the termination of a same-gender domestic partnership it is the employee's responsibility to make necessary changes within the state's electronic benefit enrollment system within the proper timeframe.

2. The employee must complete and submit a "Termination of Same-Gender Domestic Partnership Affidavit" form to their agency Benefit Administrator within the proper timeframe.

3. Review, sign and date this Affidavit form and have this Affidavit form notarized.

4. Completing this Affidavit form will end the eligibility of your same-gender domestic partner and the children of your same-gender domestic partner to be enrolled in the medical, dental, optional life and/or Flexible Spending Account (FSA) employee group benefit plans offered by the State of Colorado.

EFFECTIVE DATE

Effective Date of the Termination of Same-Gender Domestic Partnership _____

- Same-Gender Domestic Partner's Name _____
- Same-Gender Domestic Partner's Date of Birth _____
- Same-Gender Domestic Partner's Social Security Number _____

REPRESENTATIONS

A. I no longer share an exclusive, committed relationship with the above same-gender partner.

B. I understand that following the termination of a same-gender domestic partnership it is the employee's responsibility to make necessary changes within the state's electronic benefit enrollment system within the proper timeframe.

C. I understand that it is the employee's responsibility to submit a "Termination of Same-Gender Domestic Partnership Affidavit" form to their agency Benefit Administrator within the proper timeframe.

D. I acknowledge that the termination of my same-gender domestic partnership is a permanent termination of the relationship and will result in terminating the eligibility of my same-gender domestic partner and the children of my same-gender domestic partner for enrollment and coverage in the medical, dental, optional life and/or the Flexible Spending Account (FSA) employee group benefit plans offered by the State of Colorado and for no other purpose.

E. I understand that medical, dental, optional life and/or Flexible Spending Account (FSA) coverage that is currently in effect will remain in effect until the last day of the month of this Affidavit or at such time as coverage terminates in accordance with the terms and conditions of applicable plan documents and policies.

F. I understand that following an employee's termination of a same-gender domestic partnership that a minimum of one year (12 consecutive months) must elapse before an employee is eligible to add another same-gender domestic partner to their benefit coverage.

G. I understand that a termination of same-gender domestic partnership may have other legal consequences and implication to the taxability of the state employee group benefit plans and/or to the taxability of benefits provided.

H. I understand that COBRA coverage will be offered to a same-gender domestic partner and to the eligible children of a same-gender domestic partner for loss of state employee group benefit coverage caused by termination of a same-gender domestic partnership.

I. I understand that before signing this Affidavit form it is my responsibility to seek competent legal, tax and accounting advice concerning such matters.

J. I acknowledge that the State of Colorado has provided me with no advice in this regard.

AUTHORIZATION AND SIGNATURE

Upon signing this Affidavit form I represent that the information contained herein is true and complete to the best of my knowledge and that this agreement becomes effective on the date entered below.

_____ _____

DATE DEPARTMENT / DIVISION

_____ X_____

EMPLOYEE'S NAME (Please Print) EMPLOYEE'S SIGNATURE

_____ _____

EMPLOYEE'S DATE OF BIRTH EMPLOYEE'S SOCIAL SECURITY NUMBER

NOTORIZATION – FOR BENEFIT PURPOSES ONLY

Sworn to before me this _____ day of _____, 20_____

X_____ _____

Notary Public My Commission Expires

_____

Notary Public's Address

It is unlawful for any person to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, electronic benefits enrollment system, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's employee group benefit plans, civil damages, termination of enrollment in any or all of the state's employee group benefit plans, or as provided in regulations, statutes, and written directives.