

**EUTF DECLARATION OF TERMINATION OF
DOMESTIC PARTNERSHIP OR CIVIL UNION**

I. DECLARATION:

I, _____, an employee-beneficiary of the EUTF or a former domestic partner or civil union partner of an employee-beneficiary of the EUTF, declare that, as of _____ (date), am no longer in a domestic partnership or civil union partnership with _____ because:

our domestic partnership or civil union partnership no longer meets all the status criteria set forth in our declaration of domestic partnership or civil union partnership, or

the domestic partner or civil union partner deceased as of _____ (date), or

our domestic partnership or civil union partnership terminated or dissolved as of _____ (date).

II. TERMINATION OF COVERAGE:

I understand that termination of coverage of the domestic partner or civil union partner and the domestic partner's or civil union partner's dependent children, if any, will be effective upon the EUTF's receipt of this Declaration.

I affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

Employee-Beneficiary Signature
(or former Domestic Partner's or Civil Union Partner's Signature)

Date

Employee-Beneficiary Address

Domestic Partner or Civil Union Partner Address