

Miami Dade College
Declaration of Termination of Domestic Partnership

I, _____, certify and declare that
(Print employee's name)
_____ and I are no longer domestic partners
(Print partner's name)

as of ____/____/____.
(Termination date)

I understand that health coverage for my partner and his/her dependent children (if any) will terminate as of the end of the month this Declaration of Termination is received in the Benefits Department of Miami Dade College.

1. The Declaration of Domestic Partner attested to and filed by me with Miami Dade College shall be and is terminated as of the termination date.
2. The termination of the Declaration of Domestic Partnership is a result of either termination of the partnership or death of the partner.
3. I understand that another Declaration of Domestic Partnership cannot be filed until twelve months have elapsed from the date the partnership ends (as indicated above).
4. In the event that termination of this partnership is not due to the death of my domestic partner, I have mailed a copy of this notice to my former domestic partner at:

(Former domestic partner's address)

I affirm, under penalty of perjury, that the above statements are true and correct.

(Employee's signature)

(Today's date)

