



## Affidavit of Termination of Domestic Partnership

I, \_\_\_\_\_, \_\_\_\_\_, certify that I previously  
(Employee's Name - Print) (Employee's SSN or UWS Person ID)

filed an Affidavit of Domestic Partnership. I now inform the University of Wisconsin System that

\_\_\_\_\_ is no longer my domestic partner as of \_\_\_\_\_.  
(Former Partner's Name) (Date)

I understand that by filing this Termination of Domestic Partnership my former domestic partner will no longer be eligible for fringe benefit plans which he/she were formerly enrolled as my eligible domestic partner. This ineligibility also extends to the legal dependents of my former domestic partner.

**This domestic partnership has terminated because:**

- We are no longer in a committed relationship of mutual support and caring for one another.
- My domestic partner has become my spouse as legally recognized under Wis. Stat. §765. I wish to change his/her status for all UWS-sponsored insurance benefits for which he/she is already enrolled as my dependent. I understand that he/she may be eligible for additional insurance plans as my spouse and that I have 30 days from the date of marriage to complete and submit the appropriate enrollment forms to my payroll/benefits office.

I understand by filing this Termination of Domestic Partnership that a subsequent Affidavit of Domestic Partnership may not be filed for at least 6 months.

\_\_\_\_\_  
(Employee Signature) (Date)

Please return completed form to the Office of Human Resources within 30 days of the loss of the domestic partner's eligibility. Failure to notify the University may result in out-of-pocket expenses for which I may be responsible.

For Employer use only. Date received: \_\_\_\_\_ By: \_\_\_\_\_  
 Plans Impacted: Individual and Family Life \_\_\_ AD&D \_\_\_ Dental \_\_\_ Vision \_\_\_ LTC \_\_\_