AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP FOR STATE OF MAINE GROUP PLANS

I, _____ (Employee), certify that on _____, 20____, the domestic partner relationship between myself and _____ (Domestic Partner) has dissolved.

A domestic partnership ends when:

- The partners no longer share the same primary residence; or
- The partners no longer share financial obligations; or
- The partners are no longer responsible for each other's welfare; or
- One or both of the partners legally marries another person; or
- One of the partners dies

I certify under penalty of perjury, that the information contained on this form is true and correct. I, the undersigned employee, understand that the falsification of information may lead to disciplinary action up to and including immediate termination of the employee's employment, and may subject us to civil action to recover any losses, including reasonable attorney's fees incurred by the State of Maine or by its Plan Administrator for the benefits provided.

Employee Signature: _____ Date: _____ Social Security #: _____

Department Name: _____

Address: _____ City: _____ Zip: _____

Return form to Employee Health, Wellness, & Workers' Compensation
114 State House Station, Augusta, ME 04333-0114