TERMINATION OF DOMESTIC PARTNERSHIP

Send completed form to HR Shared Services (HRSS@thgrp.com)

Employee Information			
Employee Legal Name (First, Middle Initial, Last):		Social Security Number:	
Domestic Partner Information			
Domestic Partner Legal Name (First, Middle Initial, Last):		Social Security Number:	
Mailing Address:	City:	State:	Zip Code:
Dependent Information Children to be removed from Benefits due to end of Domestic Partnership			
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
Name:		Date of Birth:	
Declaration of Termination of Domestic Partnership			

I, the undersigned, do declare that:

I, _____, file this Termination of Domestic Partnership to revoke
(Print name of Employee)

the Affidavit of Domestic Partnership previously filed by me.

This relationship ended on _____/_____/_____.

I certify that the foregoing information is true and correct and understand that a false declaration of the domestic partnership or failure to file a timely notice of Termination of a Domestic Partnership form with your HR Representative will result in termination of health benefits for the domestic partner and domestic partner's child(ren) retroactive to the time the criteria ceased to be true.

Furthermore, we agree that in the event of a false declaration, or failure to file a Termination of a Domestic Partnership form with the company, the company may recover damages from either or both of us for all costs and expenses incurred by the company because of that false declaration, including, without being limited to, attorneys' fees incurred by the company to recover such damages.

Employee Signature:	**Date:**