OREGON EDUCATORS OEBB BENEFIT BOARD

Termination of Domestic Partnership Form

- Office Use Only -

Received by _____

Date_____

Submit completed form to your Educational Entity.

1. Employee Information

Educational Entity	Employee ID, SSN, or E Number

Last Name	First Name	MI	Date of Birth	Gender
				☐ M ☐ F

Contact Address	☐ Check if New Address	Apt #	City	State	Zip

Work E-mail	Personal E-mail	Work Phone	Home Phone

2. Former Domestic Partner's Information

Last Name	First Name	MI	Date of Birth
			_ _ / _ _ / _ _ _ _

Current Address	City	State	Zip

You must report to your employer's benefits administrator within 31 days after a person enrolled as your spouse, domestic partner or dependent child becomes ineligible for benefits. If you make this report on time, the change will be effective the first of the month after your report. If you do not report this change on time, OEBB may consider that an intentional misrepresentation of a material fact, for which OEBB may terminate the family member's coverage effective the first of the month after eligibility was lost.

3. Declaration of Termination of Domestic Partnership

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 _____
(MM-DD-YYYY)

I understand that:

- I must cancel all OEBB-sponsored insurance coverage for my former domestic partner and/or domestic partner's child(ren)
- I may not file another Affidavit of Domestic Partnership until six (6) months have passed from this date.
- I must attach the OEBB midyear change form canceling coverage for ineligible individuals.
- My former domestic partner, who filed the Affidavit of Domestic Partnership with me, may have the option to continue benefit coverage through COBRA regulation and self-payment of premiums.

_____ _____

Employee Signature Date

Submit completed affidavit to your Educational Entity. Do not mail this form to OEBB.