



STAYWELL

Mendocino County School Districts Health Plan

Dissolution of Domestic Partnership / Non-Spouse Cohabitants

Instructions: Complete the information below, sign and date the form. Please return the completed form to your employer.

Employee Name: _____ **Social Security Number:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Domestic Partner Name: _____

Dissolution of Domestic Partnership / Non-Spouse Cohabitants:

- I am no longer in a domestic partner relationship.
- If termination is caused by death or marriage of your domestic partner, please indicate the date of death or date of marriage. **Date:** _____

I declare that all the above statements are true and correct regarding the dissolution of my domestic partnership.

Employee Signature: _____ **Date:** _____

You could be charged with both perjury and filing false documents if you knowingly provide incorrect information on this document.