



State of New York  
 Department of Civil Service  
 Alfred E. Smith State Office Bldg.  
 Albany, NY 12239

**EMPLOYEE BENEFITS DIVISION**  
 TERMINATION OF DOMESTIC PARTNERSHIP

PS-425.4 (5/11)

I, \_\_\_\_\_ certify that:  
*Name of Enrollee (Please Print)*

1. I \_\_\_\_\_ and \_\_\_\_\_  
*Name of Enrollee (Please Print)* *Name of Domestic Partner (Please Print)*

have terminated our domestic partnership.

2. I affirm that the effective date of termination of this domestic partnership is: \_\_\_\_\_  
 Date

3. I affirm that a copy of this termination statement has been or will be provided to my former domestic partner within 14 days of termination of this domestic partnership.

4. I understand that I may not enroll another Domestic Partner, or reenroll the same domestic Partner, until **one year** after the date the Termination of Domestic Partnership form is filed.

5. I understand that my partner's children named below, if any, that are covered under my NYSHIP enrollment will end (unless otherwise eligible) on the termination date of this domestic partnership.

Domestic Partner's child's/children's name (s) \_\_\_\_\_  
 \_\_\_\_\_

6. I affirm that assertions in this notice are true to the best of my knowledge and understand that any false or misleading statements made subject me to financial responsibility for any benefits paid on behalf of my partner and/or my partner's children. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties and in other legal actions such as the prosecution of insurance fraud.

Signature of Enrollee ( <i>sign in the presence of a Notary</i> ):	Date:
Social Security Number:	

Sworn to before me \_\_\_\_\_ this day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 NOTARY PUBLIC

**Personal Privacy Protection Law Notification**

The information you provide on this application is requested for the principal purpose of discontinuing coverage provided to a domestic partner under the New York State Health Insurance Program, Dental Program, Vision Program, and/ or Employee Benefit Fund Program. The information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may prevent the Department from processing your request. This information will be maintained by the Director, Division of Employee Benefits, NYS Dept. of Civil Service, Alfred E. Smith State Office Building, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375. **For more information concerning the Domestic Partnership Program, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.**