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

EMPLOYEE BENEFITS DIVISION

Termination of Domestic Partnership for Enrollees
Of Participating Agencies

PS 427.4 (10/06L)

I, _____ certify that:
Name of Employee (Please Print)

1. I _____ , and _____
Name Of Employee (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 fourteen days of termination of this domestic partnership.

4. I understand that another Application for Benefits for a Domestic Partner cannot be filed until one year after this statement of termination of the previous partnership has been filed with my employing Agency's Health Benefits Administrator.

5. I affirm that assertions in this notice are true to the best of my knowledge and understand that false statements or failure to provide timely notification of the termination of the partnership may require payment by myself of claim amounts incorrectly paid on behalf of my former partner listed above. I understand that false statements may result in disciplinary action by my employer or in other legal actions appropriate to the prosecution of insurance fraud.

Signature of Employee:
Date:
Social Security Number:

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 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, Albany, NY 12239. For information related only to the Personal Privacy Protection Law, call (518) 457-9375.

For information, related to the Domestic Partnership Program, contact your Agency Health Benefits Administrator. If, after calling your Health Benefits Administrator, you need 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.