MCSIG
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NOTIFICATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I declare under penalty of perjury under the laws of the State of California that the statements below are true and correct.

The domestic partnership between:

_____ and _____

Print or Type Name Print or Type Name

Terminated on: _____, _____

I acknowledge that I have been informed of the following:

(A) Coverage for the domestic partner and his or her child(ren) terminates at the end of the month in which the domestic partnership terminates.

(B) If coverage for a domestic partner and or his or her child(ren) is terminated, the domestic partner and his or her child(ren) shall not be permitted to re-enroll, unless termination of coverage was due to enrollment in another group health insurance plan available to them and they seek to re-enroll with MCSIG within thirty (30) days of the end of such other coverage. This does not prevent a person who was enrolled as a domestic partner and his or her child(ren) from enrolling again if he or she becomes an employee or becomes the domestic partner of an active, covered employee and satisfies the Domestic Partner Eligibility requirements.

(C) Continuation Coverage:

1. Domestic partners and their children are not entitled to COBRA continuation coverage under federal law and therefore are not entitled to COBRA continuation coverage under MCSIG.
2. A domestic partner cannot qualify for State Continuation Coverage under California Labor Code 2800.2 and attendant California statutes.

Please provide the following information on your former domestic partner:

_____
Former Domestic Partner's Name

New Address:
_____
_____
_____

_____
Social Security #

_____
Participant's Signature

_____
Print or Type Participant's Name

_____
Participant's Social Security #