Broward Community College
Opening doors to a brighter future

BROWARD COMMUNITY COLLEGE

Group Health and Dental Plans

AFFIDAVIT OF TERMINATION OF DOMESTIC PARTNERSHIP

1. I,_____ , certify, under penalty of perjury, that
   Name of Employee (Print)
   _____and I no longer reside together and share the
   Domestic Partner (Print)
   common necessities of life, and that the effective date of the termination of this domestic partnership is _____.
   (Date)

2. I understand that a copy of this termination statement will mailed to the former Domestic Partner, unless s/he has signed this affidavit.

3. I understand that another Affidavit of Domestic Partnership cannot be filed until one (1) year after this statement of termination of this Domestic Partnership.

4. I am providing the information in this Affidavit to be used by the College for the sole purpose of determining our eligibility for domestic partnership benefits. I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or pursuant to a court order.

5. I affirm, under penalty of perjury, that the assertions in this Affidavit are true to the best of our knowledge.

Date _____Signature of Employee _____

Social Security Number_____

Date _____Signature of Domestic Partner _____

Social Security Number_____