Affidavit of Termination of Domestic Partnership

Declaration

I, _____ certify
Employee Name (Print)

that on or about _____ the Domestic Partner relationship
Month/Day/Year

between myself and _____ (Domestic Partner) has dissolved.
Domestic Partner Name (Print)

Domestic Partner Dissolution - A Domestic Partnership ends when:

- The Partners are no longer each other's sole Domestic Partner; or
- The Partners no longer share the same common residence(s); or
- The Partners no longer assume mutual obligations for the welfare and support of each other; or
- Death of one of the Partners.

I acknowledge that we no longer meet the criteria set forth in the Contra Costa Community College District's Affidavit of Domestic Partnership form, and we will no longer be considered Domestic Partners.

I also acknowledge that I will send a completed and signed copy of this Affidavit of Termination of Domestic Partnership to my former Domestic Partner's last known address and the original to the District Office Human Resources Department Benefits Division within 5 business days of signing this affidavit.

I acknowledge that if our domestic partnership was registered with the State of California or other jurisdiction, I must submit a filed copy of the State 'Notice of Termination of Domestic Partnership' (SEC/STATE NP/SF DP-2) or a copy of a final judgment of dissolution or nullity of the domestic partnership for a California registration (or equivalent form from another jurisdiction, if applicable) and that this form, by itself, will not be sufficient as proof of the termination of the domestic partnership.

Employee First Name	**Employee Last Name**	
Address	**City**	**Zip Code**
Home or Cell Phone Number	**Social Security Number**	**Birth Date**

Former Domestic Partner First Name	**Former Domestic Partner Last Name**	
Address	**City**	**Zip Code**
Home or Cell Phone Number	**Social Security Number**	**Birth Date**

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True [ ]	False [ ]	***My former domestic partner has sole legal and physical custody of dependent children that have health benefits through the Contra Costa Community College District. If true, list information for the dependent children in the table below.***

Please list dependent children (if any) on the CCCCD plan where the domestic partner has sole legal and physical custody.

Last Name	First Name	SSN	Birth Date

I certify that the information provided in this document is complete, accurate and correct.

Employee Signature		**Date**	