

The United States Life Insurance Company in the City of New York

New York, New York

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066

Phone: 1-877-672-1648 Fax: 1-877-672-1650

\*This company does not solicit business in New York.

<b>Employee Information</b>	
Name:	Group Policy Number:
Address:	Employer:
Social Security Number:	Certificate Number:

<b>Domestic Partner Information</b>
Name:
Address:
Social Security Number:

I, \_\_\_\_\_, submit this Affidavit of Termination of Domestic Partnership in order to  
*(Name of Employee)*

cancel the Affidavit of Domestic Partnership Previously filed with respect to \_\_\_\_\_  
*(Name of Domestic Partner)*

I wish to cancel the affidavit for the following reason:

- The relationship between \_\_\_\_\_ and me ended on \_\_\_\_\_.  
*(Domestic Partner)* *(Date)*
- My domestic partner became eligible for other coverage on \_\_\_\_\_.  
*(Date)*
- My domestic partner \_\_\_\_\_ died on \_\_\_\_\_.  
*(Domestic Partner)* *(Date)*

I understand that the effect of filing this Affidavit of Termination of Domestic Partnership is that my domestic partner and his or her child(ren), if any, will no longer be covered under The United States Life Insurance Company in the City of New York policy under which I am insured.

Furthermore, if I had certified my domestic partner and/or his or her child(ren) as tax dependent, I understand that I may be liable for taxes due to terminating this coverage.

In the event that termination of this relationship is not due to the death of my domestic partner, I will mail my former domestic partner a copy of this notice within 30 days at the following address:

\_\_\_\_\_  
*(Domestic Partner)*

\_\_\_\_\_  
*(Address)*

\_\_\_\_\_  
*(Your Signature)*

\_\_\_\_\_  
*(Date)*