CONFIDENTIAL

STATEMENT OF DISSOLUTION OF DOMESTIC PARTNERSHIP

I, _____, Social Security Number _____
Employee - Print Name

and I, _____, Social Security Number _____
Domestic Partner - Print Name

file this Statement of Dissolution of Domestic Partnership in order to cancel or revoke the Montgomery County Affidavit for Domestic Partnership previously filed.

We declare and acknowledge that our relationship no longer meets all of Montgomery County's

criteria to qualify as a Domestic Partnership effective as of _____.
Date (print)

We understand that if the domestic partner and/or their dependent children have been covered by Montgomery County's group health, prescription, dental or vision coverage, the effect of our relationship no longer meeting Montgomery County's criteria for a Domestic Partnership is that the domestic partner and/or their eligible dependents, if any, are no longer eligible to be covered by Montgomery County's group health, prescription, dental or vision coverage, in accordance with the terms of the underlying plan. The above is subject to any provisions in such plan permitting the continuation of coverage in the event of termination of a Domestic Partnership relationship.

I, _____, understand that this Statement of Dissolution of Domestic
(Employee – print name)
Partnership is irrevocable and that I will be eligible to submit another Montgomery County Affidavit for Domestic Partnership only when I satisfy all the requirements as outlined in the Affidavit.

_____ _____
Employee's Signature Date

Subscribed and sworn to before me this _____ day of _____ 20___.
State of _____
County of _____ _____
, Notary Public

My commission expires_____

_____ _____
Domestic Partner's Signature Date

Subscribed and sworn to before me this _____ day of _____ 20___.
State of _____
County of _____ _____
, Notary Public

My commission expires_____

MONTGOMERY COUNTY GROUP INSURANCE PLANS DEPENDENT DELETION FORM

Please read the back of this form before completing and please print legibly.

To delete an ineligible dependent, complete the following section.

SOCIAL SECURITY NUMBER	**DEPENDENT'S NAME** (AND ADDRESS IF DIFFERENT FROM PARTICIPANT'S)	**DATE OF BIRTH**	**GENDER**	**REASON NOT ELIGIBLE FOR COVERAGE** (see reverse for documentation requirements)	**EFFECTIVE DATE**

I certify that all the information I have provided on this form, as well as the documentation I have attached, is accurate. I understand that enrollment in benefits to which my dependents are not entitled is considered fraud and if I or fail to take the necessary action to remove ineligible dependents or in any way obtain benefits to which I am not entitled, my benefits will be canceled, I may be required to repay any claims which have been paid inappropriately, and I may face charges and/or dismissal from County service.

I also understand that forms submitted without the required documentation will not be processed.

Open Enrollment changes are effective January 1st. Qualified Status Changes must be submitted within 60 days of the event. If notification is received by OHR after 60 days of a Qualified Status Change, the dependent, who otherwise may be entitled to elect COBRA, will not be offered COBRA continuation of coverage. Any dependent for whom coverage is cancelled by an Open Enrollment election is not eligible for COBRA continuation coverage.

Signature _____ Date _____

Name (Please Print) _____ Social Security No. _____

SUBMIT WITH COMPLETED ENROLLMENT FORM Daytime Phone Number _____

Ineligible Dependents for Health Coverage

An ex-spouse is not eligible to participate in the Group Insurance Plan and is not permitted to remain a covered dependent. After a divorce, you must notify OHR within 60 days to delete coverage by completing a Dependent Deletion Form and providing a copy of your divorce decree.

If a dependent is no longer eligible to participate in the Group Insurance Plan (e.g., married), it is your responsibility to notify the County and delete that dependent using a Dependent Deletion form. You may also delete a dependent within 60 days of another Qualified Status Change (refer to the Summary Description for more details) or during Open Enrollment.

Proof of ineligibility is required before your dependent's group insurance coverage will be deleted. If the required documentation is not attached to this form, it cannot be processed.

For Spouse or Domestic Partner	For Unmarried Children	For Court Ordered Cessation of Support/Legal Guardianship
To delete a Spouse: Divorce decree; death certificate	**For a Biological, Adopted or Step Child**: marriage certificate; death certificate; proof of employment change	Copy of Signed Court Order no longer requiring Insurance Coverage Copy of Signed Court Order indicating change in Legal Guardianship
To delete a Domestic Partner: Statement of Dissolution of Domestic Partnership Affidavit; death certificate		

COBRA (Continuation of Coverage)

- Any dependent who is deleted because he/she is no longer eligible to participate in the Group Insurance Plan will be offered notice of his or her right to continue coverage (refer to your Summary Description for more information) if OHR is notified within 60 days of the ineligibility.
- Any eligible dependent for whom coverage is cancelled by an Open Enrollment election is not eligible for COBRA continuation coverage.
- If notification is received by OHR after 60 days of a dependent's ineligibility to participate in the Group Insurance Plan, the dependent will be removed from coverage and COBRA will NOT be offered.

CHANGE IN STATUS

- Open Enrollment changes will be effective January 1st of the following year.
- Any mid-year changes, due to a Qualified Status Change must be submitted within sixty (60) days of the event.