

Purpose: You complete this form to in order to notify the Active Plan ("Plan") sponsored by the IBEW 125 –PGE Health and Welfare Trust that your domestic partnership has terminated.

IMPORTANT POINTS TO REMEMBER

- A. Your domestic partner (and your domestic partner's children, if applicable) will no longer be eligible for coverage under the Plan.
- B. Your domestic partner (and your domestic partner's children, if applicable) **are not** eligible for COBRA benefits and thus cannot continue to pay for coverage under the Plan on their own.
- C. You cannot file a new Affidavit of Domestic Partnership for six (6) months after filing this statement.
- D. You are responsible for notifying your domestic partner that this statement has been filed with the Plan.

Section 1: Statement of Termination

I certify by signing this statement that I am no longer in a domestic partnership with the person identified below. I understand that coverage for my former domestic partner (and my former domestic partner's children, if applicable) will end on the last day of the month in which I execute this statement. I am making this Statement of Termination of Domestic Partnership because I no longer meet all of the requirements for establishing a domestic partnership as set forth in the Affidavit of Domestic Partnership I previously filed with the Plan.

I have mailed a copy of this signed Statement of Termination of Domestic Partnership to my former domestic partner as follows:

Print Name of Former Domestic Partner

Address: _____

Print Name of Domestic Partner's Children:

I certify under penalty of perjury, under applicable federal and state laws, that the foregoing is true and correct.

Print Member Name

Member Signature

Date Signed: _____