PSSU Local Unit Health and Welfare Fund

Domestic Partnership Termination Statement

We, _____ and _____,
(Print Employee Name) (Print Domestic Partner Name)
certify that we are no longer domestic partners and request that our domestic partnership be terminated. We understand that this termination is effective immediately.

_____ _____
Signature of Employee Signature of Partner

_____ _____
Date Date

On this _____day of _____, 20_____, before me appeared _____ and _____, the affiants, who being duly sworn, affirm that the facts contained therein are true and correct.

_____
Notary Public