

ACTIVE

CONFIDENTIAL

CITY OF LOS ANGELES
DEPARTMENT OF WATER AND POWER

STATEMENT OF TERMINATION OF DOMESTIC PARTNERSHIP

I _____ , affirm the termination of my domestic
Employee Name (print)

partnership with _____ , effective _____ .
Domestic Partner's Name (print) Date

I have provided a copy of this Statement of Termination of Domestic Partnership to my former domestic partner.

I understand that I will not be able to file a new Affidavit of Domestic Partnership until twelve (12) months after I have filed this Statement of Termination of Domestic Partnership with the Department of Water and Power's Health Plans Administration Office, Room 564. I further understand and acknowledge that the Department of Water and Power is not obligated to provide any domestic partnership employee benefits to me under any ordinance or memorandum of understanding until twelve (12) months after I have filed this Statement of Termination of Domestic Partnership and a new validly executed Affidavit of Domestic Partnership has been filed with the Department of Water and Power's Health Plans Administration Office, Room 564.

I declare, under penalty of perjury, that the forgoing is true and correct under the laws of the state of California, to the best of my personal knowledge.

Employee Signature

Date

Date of Birth

Employee Number

Note: By completing this form, you are only terminating your domestic partner from receiving health and dental benefits, only. If you would like for your domestic partner to be terminated from receiving Retirement Plan benefits, you must complete a separate termination form with the Retirement Office in Room 357, (213) 367-1692.