

Affidavit of Termination of Same-Sex Domestic Partnership and/or Sponsored Dependency Status

I, _____ OSU Employee ID Number (required)
(Name of Faculty/Staff Member – Print)

certify that I previously filed an Affidavit of Same-Sex Domestic Partnership or Sponsored Dependency for the individual named below with the Office of Human Resources to establish eligibility for benefit coverage, and I now inform Ohio State that

_____ no longer meets the eligibility requirements for
(Name of former Same-Sex Domestic Partner or Sponsored Dependent – Print)
 same-sex domestic partnership or sponsored dependency as of _____ .
(Date)

I understand that the individual identified above is no longer eligible for any university benefits as described online at hr.osu.edu/benefits/benefitseligibility.

I certify that, in addition to this Affidavit, I am submitting within 31 days of the termination of the relationship to the Office of Human Resources the necessary forms for the purpose of canceling any Ohio State benefit plan coverage(s) in which this individual was enrolled. These forms are available online at hr.osu.edu/forms/#domesticpartnership or hr.osu.edu/forms/#sponsoreddependents.

I also certify that I will provide the above named individual, within 31 days of the termination of the relationship, with a signed copy of this Affidavit at the following address (please print):

- Same Sex-Domestic Partner Sponsored Dependent

 Former Same-Sex Domestic Partner or Sponsored Dependent's Name

 Street Address

 City/State/Zip Code
(The university will use the above address to mail Health Plan Continuation of Coverage information to your former same-sex domestic partner or sponsored dependent, unless another address is provided.)

I understand that another Affidavit of Same-Sex Domestic Partnership or Affidavit of Sponsored Dependency cannot be filed for this individual, or if this individual was my opposite-sex domestic partner, another Affidavit of Sponsored Dependency or Affidavit of Same-Sex Domestic Partnership, may not be filed for any individual with whom I wish to establish a new domestic partnership, until six months after this relationship has been terminated. I also understand that this form will be filed with the Office of Human Resources.

 Signature of Faculty/Staff member Date Daytime Phone # Email

Return this form with your Benefit Election Form(s) to: The Ohio State University, Office of Human Resources, Benefits Processing/SSDP, Suite 300, 1590 North High Street, Columbus, OH 43201-2190