

INDIANA STATE UNIVERSITY
Statement of Dissolution of Same Sex Domestic Partnership Benefits

I hereby certify to Indiana State University that the Same Sex Domestic Partnership entered into by and between me and the partner listed below has been terminated.

I understand that pursuant to Indiana State University's Same Sex Domestic Partner Benefits policy, another Affidavit of Domestic Partnership cannot be filed to qualify for domestic partner benefits until at least 12 consecutive calendar months have elapsed from the date of this signed termination form.

I also affirm that a copy of this signed termination statement will be mailed to the below-noted partner.

Please print employee name

Please print domestic partner name

Date of Termination: _____

Address of domestic partner

Reason for Termination: _____ Separation/Dissolution of Partnership

 _____ Death of Domestic Partner

 _____ Other

Employee Signature

Date