Notice of Termination of a Domestic Partnership

Upload your completed form to Cummins Health Benefits Service Center at cumminshealthbenefits.com.

I submit this Notice of Termination of a Domestic Partnership as notice that my domestic partner is no longer eligible.

Employee Information:

Employee Name: _____

Employee Social Security Number: _____

Employee WWID: _____

Employee Date of Birth: _____

Domestic Partner Information:

Domestic Partner Name: _____

Domestic Partner Social Security Number: _____

Domestic Partner Date of Birth: _____

Domestic Partner Dependents Covered: _____

_____

My domestic partner is no longer eligible to obtain benefits through the Cummins benefit plans. We no longer meet the requirements for domestic partnership as set forth in my Affirmation of Domestic Partnership.

I acknowledge that there may be tax consequences as a result of this termination and that six months must elapse before another (or same) partner may be enrolled.

Upon signing the Notice of Termination of a Domestic Partnership, I will provide a copy to my former domestic partner.

Employee Signature: _____

Date: _____

**This form must be signed and dated to be valid*