

State of Illinois
Group Insurance Program
**Termination of Group Insurance Coverage for
Domestic Partner**

Termination of Domestic Partnership Affidavit

I, _____, submit this Termination of Domestic
(Member)

Partnership Affidavit in order to terminate the Domestic Partnership Affidavit previously filed
with respect to _____.
(Domestic Partner)

I understand that the effect of filing this Termination of Domestic Partnership Affidavit is that my
Domestic Partner will no longer be covered under the State of Illinois Employees Group
Insurance Program.

Signature: _____ Date: _____

Termination of Group Insurance Coverage

I wish to terminate my Domestic Partner's enrollment in the State of Illinois Employees Group
Insurance Program due to my Domestic Partner (check one):

- Becoming eligible for other group insurance coverage on _____.
- Getting married on _____.
- Death that occurred on _____.
- Other – Please specify reason: _____
_____.

I understand that the effect of filing this Termination of Domestic Partner's Group Insurance
Coverage is that my Domestic Partner will no longer be covered under the State of Illinois
Employees Group Insurance Program.

Signature: _____ Date: _____

BENEFITS STAFF USE ONLY

GIR Name: _____ Date: _____

Effective Date of Termination: _____ Termination Code: _____