



GUARDIAN™ The Guardian Life Insurance Company of America

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Lehigh Valley PA 18002-6050

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**Statement of Termination
of Domestic Partnership**

Coverage for a Domestic Partner **and his or her children, if included**, terminates upon any change of one or more circumstances or criteria attested to in the Declaration of Domestic Partnership. Coverage will also terminate when the employee dies.

Upon termination of a Domestic Partnership, this form must be completed and filed with your Employer within 30 days of the change. After termination, a Declaration to add a new domestic partner cannot be filed for a period of at least 12 months from the filing of this statement.

All Questions Must Be Completed

1. Employee Name _____ Social Security # _____

2. Planholder Name _____ Group Plan # _____

3. Reason For Termination: Change in eligibility criteria Death of my Domestic Partner Date: _____

4. Provide complete information for the person to be terminated:

Name of Domestic Partner (Last, First, MI) _____

Social Security Number: _____ Sex: M F BirthDate: _____

I represent that all statements and answers given above are true, complete and correct.

Signature of Employee Date

Signature of Planholder Date