PEBB Termination of Domestic Partnership
Instructions
www.oregon.gov/DAS/PEBB

Complete this form to term a domestic partnership established under a **PEBB Affidavit of Domestic Partnership**. Submit this form along with the appropriate update form to your agency/university payroll or benefit office.

- The effective date for termination of coverage due to lose of eligibility is the last day of the month the event occurred.

SECTION A
- Complete each item in this section

SECTION B
- Complete each item in this section for domestic partner.

SECTION C
- Read and complete each item in this section.

SECTION D
- Read sign and date the form.
- Make a copy for your records and submit. **Sending your forms to the wrong address will delay your change**.

Active and Semi Independent Agency Employees:

Within 60 days of QSC to: Agency/University Payroll,
Personnel or Benefit Office

Beyond 60 days of QSC to: PEBB
1225 Ferry St. SE
Salem, OR 97301
Salem (503)-373-1102
Toll-free (800)-788-0520

COBRA and other Self-Pay Participants Only to:
BenefitHelp Solutions (BHS)
PO Box 67240
Portland, OR 97268-1240
Portland (503)-765-3581
Toll-free (800)-556-3137

Termination of Domestic Partnership

SECTION A – EMPLOYEE INFORMATION					
LAST NAME	**FIRST NAME**	**MI**	**ID NUMBER (SSN, OURS#, Benefit#)**		
DATE OF BIRTH (MM-DD-YYY)		**GENDER** ☐ **FEMALE** ☐ **MALE**			
RESIDENCE ADDRESS		**CITY**	**STATE**	**ZIP**	
		COUNTY	**HOME PHONE**		
MAILING ADDRESS		**AGENCY**	**WORK PHONE**		
E-MAIL ADDRESS					

SECTION B – DOMESTIC PARTNER INFORMATION			
LAST NAME	**FIRST NAME**	**MI**	**ID NUMBER (SSN, OUS#, Benefit#)**
CURRENT ADDRESS (if known)		**DATE OF BIRTH (MM-DD-YYY)**	

SECTION C – EMPLOYEE DECLARATION AND DATE OF TERMINATION

I _____ (please print) file this PEBB Termination of Domestic Partnership form to revoke the PEBB Affidavit of Partnership previously filed by me.

This relationship ended on (MM-DD-YYYY)_____.

I understand that:

- I must cancel **all PEBB-sponsored insurance coverage** for my former domestic partner and/or domestic partner's child(ren).
- Attach the appropriate PEBB Medical and Dental and/or Life and Disability Update Form canceling coverage for ineligible individuals.
- My former domestic partner, who filed the Affidavit of Domestic Partnership with me, may have the option to continue benefit coverage through COBRA regulation and self-payment of premiums.

Employee Signature:_____ Date:_____

"PEBB Use Only"

Approved by PEBB(initials):_____ Date:_____ Effective Date: _____ PDB Updated by (initials):_____

107-026(02/05/08)