CITY OF MADISON
TERMINATION OF DOMESTIC PARTNERSHIP
FOR HEALTH PREMIUM STIPEND PROGRAM
All Employee Groups

Employee Information

Name:	**Munis ID #:**
Date of Birth:	**Department:**

Domestic Partner Information

Name:	**Date of Birth:**

Employee Certification

By my signature, I certify that was in a domestic partner relationship that satisfied the eligibility requirements of the City of Madison's Domestic Partner Health Insurance Premium Stipend/Reimbursement Program (hereafter referred to as "the Program") and that the domestic partner relationship has terminated. I understand that by terminating the domestic partnership, I am no longer eligible for a stipend or reimbursement under the Program.

_____ _____

Signature of Employee **Date of Signature**

_____ _____

Signature of Human Resources Director **Date of Signature**

City of Madison Human Resources
215 Martin Luther King Jr Blvd Ste 261
Madison, WI 53703