CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community

520 EAST HERNDON AVENUE · FRESNO, CA 93720 · 559-437-2960 · 800-288-9870 · FAX 559-437-2965 · WWW.CVTRUST.ORG

NOTIFICATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I declare under penalty of perjury under the laws of the State of California that the statements below are true and correct.

The domestic partnership between:

_____ and _____
Print or Type Name Print or Type Name

terminated on: _____, _____.

I acknowledge that I have been informed of the following:

(A) Coverage for the domestic partner and his or her child(ren) terminates at the end of the month in which the domestic partnership terminates.

(B) If coverage for a domestic partner and or his or her child(ren) is terminated, the domestic partner and his or her child(ren) shall not be permitted to re-enroll, unless termination of coverage was due to enrollment in another group health insurance plan available to them and they seek to re-enroll in this Trust within thirty (30) days of the end of such other coverage. This does not prevent a person who was enrolled as a domestic partner and his or her child(ren) from enrolling again if he or she becomes an employee or becomes the domestic partner of an active, covered employee and satisfies the requirements of Section II of the Domestic Partner Eligibility Policy.

(C) Continuation Coverage.

(1) Domestic partners and their children are not entitled to COBRA continuation coverage under federal law and therefore are not entitled to COBRA continuation coverage under CVT.

(2) A domestic partner cannot qualify for State Continuation Coverage under California Labor Code 2800.2 and attendant California statutes.

Please provide the following information on your former domestic partner:

Former Domestic Partner's Name: _____

New Address: _____

_____

Social Security #: _____

_____ _____
Participant's Signature Print or Type Participant's Name

_____
Participant's Social Security Number