

**PerfectHealth Insurance Company
Termination of Domestic Partnership**

**Send to:
Working Today Administration
4409 Parkbreeze Court
Orlando, FL 32808
Fax: 866-420-5809**

Note to Employer: Keep a copy of this document for your records and forward the original Statement attached to an appropriate Employee Enrollment and Change Form.

Group Plan Number 230000

Group Name Working Today

Member

Name _____

Home Address _____

Social Security Number _____

Birth Date _____

Domestic Partner

Name _____

Home Address _____

Social Security Number _____

Birth Date _____

I, _____, affirm that the Statement of Domestic Partnership attested to and signed by me on _____ shall be and is terminated as of this date and that I shall send notice of this termination by mailing via the United States Postal Service a copy of the signed statement to my aforesaid partner _____ within 14 days of signing this notice

Member Signature

Date