



## 2024 Affidavit in Support of Termination of Domestic Partnership

I, \_\_\_\_\_, submit this Affidavit in Support of Termination of Domestic Partnership for the sake of cancelling the Affidavit of Domestic Partnership I previously filed.

I declare and acknowledge that there has been a change in the status of the domestic partnership such that it no longer meets the eligibility criteria listed within the Affidavit of Domestic Partnership.

This has an impact on the benefits for (check one of the boxes):

- Domestic Partner only
- Domestic Partner and his/her legally eligible dependents listed below

Dependents of Domestic Partner	
Name	Date of Birth

I understand that if I commit fraud or intentionally misrepresent information in this Affidavit, it may result in any or all the following actions by Cheyenne Regional Medical Center:

- A requirement that I reimburse Cheyenne Regional Medical Center for all expenses paid.
- Termination of my employment.
- Other legal action.

I affirm that the assertions in this Affidavit are true to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_