

**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-YYYY)		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-YYYY)	

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): _____