University of Missouri System

COLUMBIA | KANSAS CITY | ROLLA | ST. LOUIS

Affidavit of Termination of Sponsored Adult Dependent Partnership

I,_____, file this Affidavit of Termination of Sponsored Adult Dependent Partnership
Employee (Print Name)

to revoke the Affirmation of Sponsored Adult Dependent Partnership previously filed with my campus benefits office.

_____, no longer meets the eligibility requirements for a Sponsored Adult Dependent
Former Partner (Print Name)

as outlined in the University of Missouri's Collected Rules and Regulations as of _____ due to
Date

☐ Death of Sponsored Adult Dependent.

☐ Termination of Partnership.

I certify that, in addition to this Affidavit, I am submitting within 31 days of the event the necessary forms for the purpose of canceling any benefit plan coverage(s) in which this individual was enrolled.

I understand that the Sponsored Adult Dependent's eligibility for health benefits ends on the last day of the month in which the Sponsored Adult Dependent partnership terminates or was terminated. Failure to notify my campus benefits office within 31 days of the termination may result in liability for benefits paid for an ineligible individual.

I understand that the former partner named above may be eligible for continuation of health benefits under COBRA regulations. Therefore, I am providing you with their address below:

Residential Street Address		
City	State	ZIP

I understand that another Affirmation of Sponsored Adult Dependent Partnership cannot be filed for this individual, or any individual with whom I wish to establish a new Sponsored Adult Dependent partnership, until twelve months after this partnership was terminated (a Sponsored Adult Dependent must have the same residence as the Employee for at least twelve months).

I further acknowledge that it is my responsibility to provide a copy of this signed Affidavit to the former partner named above.

I certify that the above information is true and correct to the best of my knowledge, and I understand that any false or omission of information on this form that constitutes fraud will be grounds for the University to rescind my coverage.

I acknowledge and agree that this document may be signed by electronic signature, which shall be considered an original signature for all purposes and shall have the same force and effect as an original signature. "Electronic signature" shall include faxed versions of an original signature, electronically scanned and transmitted versions of an original signature, and typed signature in a fillable form or typed signature via Adobe Pro.

Employee Signature		Date
Email Address	Work Phone	Employee ID (not SSN)