

New York State Nurses Association

Benefits Fund

PO Box 12430, Albany, NY 12212-2430 • (518) 869-9501 • Fax: (518) 869-2317 • www.rnbenefits.org

Statement Of Termination Of Domestic Partnership

I, _____ certify the following:
Your Name

1. _____ and I are no longer domestic partners as of _____.
Domestic Partner's Name
2. I make and file this Statement of Termination in order to cancel the Affidavit of Domestic Partnership filed by me with New York State Nurses Association Benefits Fund on_____.
3. It is understood that by filing the Statement of Termination any benefits that have been extended to a domestic partner and/or a dependent child(ren) of a domestic partner will cease.
4. I mailed my former domestic partner a copy of this notice at:

_____ on _____

I declare, under penalty of perjury, that the above statements are true and correct.

Signed _____

Print Name _____

Address _____

Date _____