WASHINGTON AND LEE
UNIVERSITY
LEXINGTON, VIRGINIA 24450-2116

DECLARATION OF TERMINATION OF DOMESTIC PARTNERSHIP

I, _____, affirm that one or all of the declaration statements made on the
Name of Subscriber

Declaration of Domestic Partnership dated _____ is/are no longer accurate.
Date of Declaration Form

I affirm that this Declaration of Termination of Domestic Partnership has been completed within Thirty-one (31) days of the date that any one of the declared statements is no longer accurate. I understand that upon the effective date of this Declaration of Termination of Domestic Partnership the individual named as my domestic partner in the Declaration of Domestic Partnership will no longer be covered as my dependent under the Group Health and Dental Plans. I further understand that any other dependents that were covered as my dependents due to my relationship with the individual named as my domestic partner will no longer be covered as my dependent under the Group Health and Dental Plans.

_____
Subscriber's signature

_____
Date

[space reserved for internal purposes]