Domestic Partner Dissolution Form

Return a copy of completed form to: Aspirus Health Plan, ATTN: Enrollment, PO Box 1062, Minneapolis, MN 55440
or email to: Enrollment@aspirusheathplan.com. If you have questions, please call Customer Service at: 866.631.5404.

We, the undersigned, attest and certify that our partnership has dissolved.

Employee Name	Domestic Partner Name

The Employee and the Domestic Partner (hereinafter referred to as "We") hereby certify that we no longer meet the qualifications of a Domestic Partnership as attested to in our "Declaration of Domestic Partnership." The Domestic Partner (and the Domestic Partner's children that do not otherwise qualify as dependents of the Employee) will be terminated from the health, dental, and/or vision plans as stated in the policy.

We affirm, under penalty of perjury, that the statements in this Declaration are true, complete, and correct.

Employee's Signature	Employee's Name *(Please print)*	Date
Domestic Partner's Signature	Domestic Partner's Name *(Please print)*	Date