Affidavit of Dissolution of Domestic Partnership

I, _____, an employee of New York Power Authority, attest that the individual named here and named on my original Affidavit of Domestic Partnership_____ is no longer deemed to be my Domestic Partner or now has their own medical as of _____ (date).

I, therefore, request that coverage under the New York Power Authority benefit plans, any imputed income (if applicable), and any payroll deductions (if applicable) for this Domestic Partner cease. The above date is within 31 days of the termination of our domestic partnership.

I have mailed a completed, signed, and notarized copy of this Affidavit of Dissolution of Domestic Partner coverage to my former Domestic Partner at _____, which is their most current address known to me.

I understand that New York Power Authority's COBRA vendor will mail a COBRA notification (if no other health insurance is available to Domestic Partner) to my former Domestic Partner at the address listed above, which is their most current address known to me.

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

Signature: _____

Sworn to before me _____this _____day of _____ , _____

_____

NOTARY PUBLIC