2021-22 Affidavit of Termination of Domestic Partner Status

I, _____, _____
Student (Print Full Name) OSU Student ID Number

certify that I previously filed an Affidavit of Domestic Partnership with the OSU Student Health Insurance Office at The Ohio State University.

I now inform the OSU Student Health Insurance Office at the Ohio State University that

_____
Name of former Domestic Partner (Print Full Name)

is no longer my domestic partner as of _____ .
Date

Please mark each statement with a check mark (✓) and sign and date:

___ I understand that as a result of signing this Affidavit of Termination of Domestic Partner Status, the partner identified above is no longer eligible for the Student Health Insurance Plan effective the first day of the following term coverage period, with no pro-rata refund of fee payment.

___ I certify that a completed copy of this Affidavit of Termination of Domestic Partner Status has been mailed to my partner identified above.

___ I understand that another Affidavit of Domestic Partnership cannot be filed until six (6) months after this domestic partnership has been terminated and this completed form filed with the Student Health Insurance Office.

_____ _____
Signature of Student Date

Return completed form to:	**Student Health Insurance** **830 Lincoln Tower** **1800 Cannon Drive** **Columbus, OH 43210** **Fax: 614-292-1170**