

DISSOLUTION OF DOMESTIC PARTNER RELATIONSHIP FORM

INSTRUCTIONS – Use this form to remove your domestic partner, and any associated dependents of the domestic partner, from the State of Montana Benefit Plan (State Plan) when your domestic partner relationship has ended.

- You must complete your on-line Life Event enrollment **within 60 days of the date your domestic partner relationship ended** at benefits.mt.gov, start by clicking on the “Benefit Enrollment and Changes” button.
- During your on-line enrollment you will be required to upload this completed form.
- Your domestic partner’s, and any associated dependents of your domestic partner, coverage ends at 11:59 p.m. the last day of the month in which your domestic partner relationship ended.
- Benefit contributions for coverage of your domestic partner, and associated dependents of the domestic partner, will continue to be charged until you have completed the on-line Life Event enrollment and submitted the Dissolution of Domestic Partner Relationship Form.
- If notification of the dissolution of domestic partner relationship is not received within 60 days of the date the domestic partner relationship ended, coverage will be terminated on the last day of the month following receipt of the notification.

EMPLOYEE INFORMATION

EMPLOYEE ID# _____ LAST NAME _____ FIRST NAME _____ MI _____

DATE OF BIRTH ____-____-____ DATE OF DISSOLUTION OF DOMESTIC PARTNER RELATIONSHIP ____-____-____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

DOMESTIC PARTNER INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____

ASSOCIATED DEPENDENTS OF THE DOMESTIC PARTNER (NAMES)

_____, _____, _____

READ AND SIGN

We, the undersigned, attest that our domestic partner relationship has ended and we agree coverage with the State of Montana Benefit Plan (State Plan) for the domestic partner, and any associated dependents of the domestic partner, should be terminated.

Employee Signature: _____ Date: _____

Domestic Partner Signature: _____ Date: _____

Acknowledgement

State of _____, County of _____

The foregoing was acknowledged before me this ____ day of _____, 20____, by _____
(Name of Affiants).

Notary Public _____

My Commission Expires _____

SEAL



Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-270-3877 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-270-3877 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-270-3877 (TTY: 711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-270-3877 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-270-3877 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-270-3877 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-270-3877 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-270-3877 (TTY: 711)번^o로 전화해 주십시오.

الصم، البكم: (117 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-270-3877 (رقم هاتف
เรียน: 'U: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร1-866-270-3877 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistentjenester tilgjengelige for deg. Ring 1-866-270-3877 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-270-3877 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-270-3877 (телетайп: 711).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kantscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-270-3877 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-270-3877 (TTY: 711).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance the State Diversity Coordinator is available to help you. You can file a grievance in person or by mail, fax, or email: State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3871 Email: SABHRSHR@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)