

SCREEN ACTORS GUILD-PRODUCERS PENSION & HEALTH PLANS

Statement Of Disenrollment, Death Or Termination Of Domestic Partnership

I, _____ make and file this statement of
(Name of Participant)
Disenrollment, Death or Termination of Domestic Partnership in order
to cancel the Affidavit of Domestic Partnership and declare and
acknowledge as follows:

I wish to cancel the Affidavit of Domestic Partnership previously
filed

with respect to _____.
(Name of Domestic Partner)

-OR-

The Domestic Partnership relationship between me and _____
(Domestic Partner)
ended on _____.
(Date)

-OR-

My Domestic Partner _____ died on _____.
(Name of Domestic Partner) (Date)

I understand that if my Domestic Partner is covered by the Screen
Actors Guild - Producers Health Plan (Health Plan), the effect of
filing this form is that my Domestic Partner's coverage will terminate
in accordance with the terms of the Health Plan.

I further acknowledge that it is my responsibility to mail a copy of
this signed statement to the Domestic Partner named above, if living.

I affirm that the statements above are true to the best of my
knowledge.

Date Print Participant's Name

Participant's Signature Address

Participant's SS# City, State, Zip Code

Print Domestic Partner's name Domestic Partner's Address

Domestic Partner's SS# City, State, Zip Code