Pension Boards
United Church of Christ

UCC Medical and Dental Benefits Plan
Flexible Benefit Plan for UCC Ministries

Statement of Disenrollment, Death or Termination of Same-Gender Domestic Partnership

PERSONAL INFORMATION

Social Security Number	First Name	Middle Initial	Last Name

Address 1	City	State	Zip	Country
Address 2				
Address 3	E-mail Address			
Telephone Number ( )				

Social Security Number	Domestic Partner's First Name	Middle Initial	Last Name

I make and file the statement of :

☐ **A. Dissolution of Same-Gender Domestic Partnership**

The same-gender Domestic Partner relationship, Civil Union or lawful same sex marriage between me and my former same-gender domestic partner or spouse, named above, terminated on ___/___/_____.

☐ **B. Death of Same-Gender Domestic Partner**

My same-gender Domestic Partner or spouse died on ___/___/_____.

Since your same-gender Domestic Partnership relationship, Civil Union or lawful same sex marriage has terminated due to one of the above reasons, you will not be able to again request health and dental coverage and/or reimbursement for a same-gender domestic partner's medical expenses under a flexible spending account (FSA) for a new same-gender domestic partner before the earliest of (1) six months following the establishment of a new same-gender domestic partnership, (2) the date of your civil union, or (3) the date of a lawful same sex marriage.

Member Signature	Date
	/ /

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