



Protective Life Insurance Company  
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Birmingham AL 35201-0096  
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Email: ada@protective.com  
Website: ada.protective.com

## Statement of Termination of Domestic Partnership

Please complete this form and return it to Protective Life by fax, email or mail. This Statement of Termination will affect any inforce coverage for your Domestic Partner under any of the ADA Insurance Plans.

This Statement of Termination of Domestic Partnership is effective as of \_\_\_\_\_.  
(Effective Date)

### ACKNOWLEDGEMENT

I \_\_\_\_\_ (print name of ADA Member) and \_\_\_\_\_  
(print name of former Domestic Partner), the signatories to this Statement of Termination (the Signatories),  
under penalty of perjury, do hereby:

Renounce and rescind the Affidavit of Domestic Partnership, which was effective as of (date) \_\_\_\_\_

- Understand and agree that on and after the Effective Date of this Statement of Termination, neither the former Domestic Partner nor any Dependents of former Domestic Partner will be eligible for any benefits under the ADA Insurance Plans.
- Affirm that the Domestic Partnership terminated due to the fact that the Signatories no longer intend to cohabit indefinitely or share the common necessities of life.
- Affirm that the circumstances, which necessitated the filing of this Statement of Termination, occurred within thirty (30) days of its Effective Date.
- Understand that any entity suffering a loss because of a false statement contained in this Statement of Termination may bring civil action against Signatories to recover direct and indirect losses, including reasonable attorneys' fees.
- Understand and agree that the information contained in this Statement of Termination is to be used by Protective Life (the Insurer) for the sole purpose of determining a Domestic Partner's eligibility for insurance under the ADA-sponsored Insurance Plans.
- The Signatories further understand that this information will remain confidential and will be subject to disclosure only upon the Signatories' express written authorization or as legally required.
- Affirm that the assertions in this Statement of Termination are true to the best of our knowledge.
- Understand that the ADA Member cannot file another Affidavit of Domestic Partnership with the Insurer until at least six (6) months after the Effective Date of this Statement of Termination.

\_\_\_\_\_  
Signature of ADA Member

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of former Domestic Partner

\_\_\_\_\_  
Date