

hrservice@syr.edu

Name of Syracuse University Employee: _____

Employee's SUID: _____

Name of Domestic Partner: _____

I hereby attest that as of _____ the eligibility criteria listed in the Syracuse University Benefits
(mm/dd/yyyy)

Eligibility Policy are no longer satisfied, and therefore the partnership is dissolved.

Signature of Employee

Date

Return this form to:

HR Shared Services

hrservice@syr.edu

Phone: 315.443.4042 Fax: 315.443.1063

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