Department of Civil Service
Employee Benefits Division

PS-425.4 (1/2026)
Termination of Domestic Partnership for NYSHIP Form
Department of Civil Service, Albany, NY 12239

I, the enrollee, certify that:

I, ______________________________ **, and** ______________________________
Name of Enrollee (Please Print) Name of Domestic Partner (Please Print)

have terminated our domestic partnership.

I affirm that the effective date of termination of this domestic partnership is: Date _ _ / _ _ / _ _ _ _

I affirm that a copy of this termination statement has been or will be provided to my former Domestic Partner within 30 days of termination of this domestic partnership.

I understand that I may not enroll another Domestic Partner, or reenroll the same Domestic Partner, until one year after the date this form is filed.

I understand that my partner's children named below, if any, that are covered under my NYSHIP enrollment will end (unless otherwise eligible) on the termination date of this domestic partnership.

Domestic Partner's child's/children's name(s): ______________________________

I affirm that assertions in this notice are true to the best of my knowledge and understand that any false or misleading statements made subject me to financial responsibility for any benefits paid on behalf of my partner and/or my partner's children. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties and in other legal actions such as the prosecution of insurance fraud.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

AUTHORIZATION

I, the enrollee, understand that any false or misleading statements made will subject me to financial responsibility for any benefits paid on behalf of my partner and/or my partner's children. I understand that false statements may result in disciplinary action by my employer and/or result in criminal and/or civil penalties and in other legal actions, such as the prosecution of insurance fraud.

▶ **Print Enrollee Name** ______________________________ **Social Security Number** _ _ _ – _ _ – _ _ _ _

▶ **Enrollee's Signature** ______________________________ **Date** _ _ / _ _ / _ _ _ _
(Sign in the presence of notary)

Acknowledgment to Be Completed by a Notary Public

State of ______________ County of ______________________________

On the ________ day of ______________ in the year ____________ before me, the undersigned, personally appeared ______________________________ , personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/ their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

▶ **Notary Public** ______________________________
(Please sign and affix stamp)