



Affidavit of Termination of Other Eligible Individual Partnership

This termination form is to be used when an MSU employee's Other Eligible Individual partnership is dissolved, or an Other Eligible Individual partner dies. By signing this form, I am affirming that the "Other Eligible Individual Form" shall be invalid as of this date: _____

Termination of the Other Eligible Individual partnership is due to:

- Other Eligible Individual partnership terminated or no longer meets the OEI program criteria, or
- Death of Other Eligible Individual partner (_____date of death)

I understand that my partner's (and his/her dependent's) coverage will continue through the end of the month of the partnership termination unless continuation of coverage is chosen.

I hereby agree to mail a copy of this signed statement to my surviving former Other Eligible Individual partner.

The non-MSU Other Eligible Individual partner (and eligible dependents) is no longer eligible for coverage through MSU's group plans but will have eligibility to continue health and/or dental coverage.

The following is the name/address of my former partner for purposes of mailing continuation of coverage information:

Signature

(month, day, year)

Printed Name

Telephone Number

For further questions, please visit [Other Eligible Individual \(msu.edu\)](http://msu.edu) or contact MSU Human Resources at solutionscenter@hr.msu.edu or 517-353-4434, 1-800-353-4434