



Complete this *Termination of Qualified Domestic Partnership* if you are a Pension Plan member, you previously filed an *Affidavit of Qualified Domestic Partnership*, and your domestic partnership has terminated.

- PLEASE TYPE OR PRINT CLEARLY -

I. MEMBER INFORMATION

Member Name _____ Member Ref. No. _____
(first) (middle) (last/family name)

Check here if there has been a change to your contact information on file.

Home Address _____

City _____ State _____ Country _____ Zip Code _____ - _____

Daytime Phone Number (_____) _____ E-Mail Address _____

II. DOMESTIC PARTNER INFORMATION

Domestic Partner Name _____ Social Security No./ITIN _____
(first) (middle) (last/family name)

III. TERMINATION OF QUALIFIED DOMESTIC PARTNERSHIP

I certify that my domestic partnership with the above-named domestic partner has terminated for the following reason (*check one only*):

- Our partnership is no longer registered with the state.** *Include with this Form a copy of your state order or other documentation that formally terminates such legal relationship.*
- Our partnership ceases to meet the criteria of a qualified domestic partnership under the Pension Plan.** *Do not check this box if your domestic partnership was established by formal recognition under state law.*
- My domestic partner died on** ____/____/____. *Include with this Form a copy of your domestic partner's death certificate.*

IV. CERTIFICATION AND SIGNATURE

By signing this Form, I make the following certifications:

- I certify that the information provided on this Form is accurate. I understand that the effect of filing this *Termination of Qualified Domestic Partnership* is that my former domestic partner will no longer be treated as a qualified domestic partner for purposes of receiving Pension Plan benefits.
- I understand that I cannot file a new *Affidavit of Qualified Domestic Partnership* before the earlier of (i) sixty (60) months from the date this Form is filed or (ii) the date on which I formally register a new domestic partnership with the state in which I reside.
- I understand that the personal information provided on this Form will be used by Pension Fund to process my benefits and to provide member services to me under the Pension Plan.

Member Signature _____ **Date** ____/____/____

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