



HEALTH CARE  
AUTHORITY

**Michelle Lujan Grisham, Governor**  
Kari Armijo, Secretary  
Kathy Slater Huff, Deputy Secretary  
Niki Kozlowski, Acting Deputy Secretary  
Alanna Dancis, Acting Medicaid Director

## State of New Mexico Health Care Authority

### NOTICE OF TERMINATION OF DOMESTIC PARTNERSHIP *Executive Order 2003-010*

*Return this form to the State Employee's Human Resources Office within 31 calendar days from the date the domestic partnership terminated*

- I, the undersigned, do declare that my former partner, \_\_\_\_\_, and I are no longer in a Domestic Partnership. *(Print Former Domestic Partner's Name)*
- (Fill out this part only if the termination is caused by death or marriage of the domestic partner; otherwise leave this blank and skip to the signature section below.)*

If the termination is caused by the death or marriage of the domestic partner, please indicate the date of the death or the marriage: \_\_\_\_\_. This date is the actual termination date of the Domestic Partnership. *(Month/Day/Year)*

I declare, under penalty of perjury, that the above statements are true and correct. *(Sign this Notice in the presence of a Notary Public.)*

\_\_\_\_\_  
Signature (Print Name)

\_\_\_\_\_  
Mailing Address City State Zip Code

STATE OF NEW MEXICO )  
)  
S  
S  
COUNTY OF \_\_\_\_\_ )  
(County Name)

SUBSCRIBED AND SWORN to this \_\_\_\_\_ day of \_\_\_\_\_ 20, by ; \_\_\_\_\_  
an employee of the State of New Mexico *(Month/Year)* *(Print Employee's Name)*

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My Commission Expires

\*Para asistencia en español con este formulario, por favor llame a EASI Gov al 1-855-618-1800