



**DISSOLUTION OF DOMESTIC PARTNER STATUS AFFIDAVIT**

I, \_\_\_\_\_ (Name of Employee) \_\_\_\_\_ (Employee ID)

Certify that I previously filed the appropriate *Domestic Partner Affidavit* with NXP USA, inc. to establish a domestic partnership and I now inform NXP USA, Inc. that:

\_\_\_\_\_ is no longer my domestic partner as of \_\_\_\_\_.  
(Name of former Domestic Partner) (Date)

I understand that the domestic partner identified above is no longer eligible for the NXP USA, Inc. benefit plan(s).

I also certify that I will provide my former domestic partner with a copy of this *Dissolution of Domestic Partner Status Affidavit* at the following address (**please print**):

Former Domestic Partner's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

I understand that:

- I have 30 days from the date of the dissolution of our domestic partnership to request to remove my domestic partner from my coverage.
- My domestic partner's coverage will end at the end of the month during which our domestic partnership termination is effective and I will be responsible for the premiums for this member until the end of the month.

\_\_\_\_\_  
(Signature of Employee) (Date Signed)