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**VALASSIS
TERMINATION STATEMENT OF DOMESTIC PARTNERSHIP**

I, _____ SSN _____ - _____ - _____ certify that
Name of Associate (print)

1. I have terminated my domestic partnership with

_____ SSN _____ - _____ - _____
Name and SSN of Domestic Partner (print)

as of the date ____/____/____

- 2. I understand that benefits will be discontinued on the date noted in (1) above; **and**
- 3. after such termination, I understand that a subsequent Affidavit of Domestic Partnership cannot be filed until twelve (12) months after the notification in writing of the termination has been filed with my Human Resources department; **and**
- 4. under penalty of perjury, I affirm that I am mailing a copy of this completed termination statement to my former domestic partner at: (Indicate Address to which notice was mailed)

on: Date/_____.

I declare that the above statements are true and correct.

Associate's Signature _____

Print Name: _____

Date: ____/____/____

Human Resources Signature: _____ Date: ____/____/____

Return completed form to your local Valassis, Human Resources Department or to the Associate Resource Center if you are a legacy ADVO associate.