Ingredion Incorporated
TERMINATION OF DOMESTIC PARTNERSHIP

NOTE: The facts attested to in this affidavit may impact on the eligibility of an individual to be covered under the Ingredion Health and Welfare Plans as the domestic partner of a plan participant.

The undersigned person, _____ (Print employee's name)

Solemnly declares to be true:

1. On _____ (date), an AFFIDAVIT OF DOMESTIC PARTNERSHIP was executed by me and _____ (domestic partner's name),the other person named in that Affidavit.

2. Because of death of such person or because of another change in circumstances, one or more of the statements attested to by me or by him/her in the AFFIDAVIT OF DOMESTIC PARTNERSHIP has ceased to be accurate.

3. The other person named in the AFFIDAVIT OF DOMESTIC PARTNERSHIP,
   a. Died on _____ (date)

OR

   b. The earliest date on which one or more of the statements attested to in the AFFIDAVIT OF DOMESTIC PARTNERSHIP became no longer accurate was (date).

4. If the other person named in the AFFIDAVIT OF DOMESTIC PARTNERSHIP is still living, I have mailed a completed and signed copy of this Affidavit to him/her on (date), addressed to him/her at:

   Which is his/her most current address known to me.

I declare, under penalty of perjury, that the above statements are true and correct.

Signature of employee _____

_____

Date Social Security Number