

**Drexel University/Benefits Office**  
**Statement of Termination of Domestic Partnership**

\_\_\_\_\_  
Employee Last Name, First Name, Middle Initial

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Domestic Partner Last Name, First Name, Middle Initial

I, the above employee, hereby declare that my domestic partnership with the above domestic partner has terminated. I understand that:

- Benefits and perquisites provided under any benefit programs sponsored by Drexel University (the "University") shall terminate as of the date hereof for my former domestic partner and any covered children who do not continue to be my tax qualified dependants.
- My former domestic partner and any of his or her children who lose coverage under the University's benefit programs as a result of the termination of my domestic partnership will be offered the opportunity to elect health care continuation coverage (i.e., COBRA coverage) under the University benefit programs. The rates for continued coverage will be the prevailing University rates plus a 2% administration fee.
- The termination of my domestic partnership will not alter any beneficiary designation in effect under any benefit programs. If my former domestic partner is named as my beneficiary under any benefit program, I may name another beneficiary on forms provided by the University's benefit office.
- In the event we resume our domestic partnership, coverage under the University's benefit programs will not be available again until I complete and satisfy the requirements of the Affidavit of Domestic Partnership.
- that the University will send a copy of this form to my former domestic partner.

\_\_\_\_\_  
Employee's Signature Date

Sworn to and subscribed before me this day of , 200\_\_.

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

My commission expires: \_\_\_\_\_