EMORY UNIVERSITY
STATEMENT OF TERMINATION OF SAME-SEX DOMESTIC PARTNERSHIP
Return to: Emory University Benefits Department, 1599 Clifton Rd NE, First Floor, Atlanta, GA 30322

Employee _____ Employee ID _____

I hereby certify that _____ and I no longer meet the eligibility requirements as "domestic partners" (for example, we no longer share financial obligations, termination of the relationship, etc.) This statement cancels the Statement of Domestic Partnership filed with Emory University. I understand that:

- Benefits provided under any Emory University benefit programs will terminate on the last day of the month following this notification.
- My former domestic partner and any of his/her dependents who lose medical, dental or vision coverage will be offered an opportunity to elect coverage continuation (COBRA).

  Domestic Partner's address _____
  (for COBRA purposes only)
  _____
- I can review and update my beneficiary designations through Self Service.
- I will send a copy of this form to my former domestic partner.

Signature of Employee _____ Date _____

Accepted by _____ Date_____
Human Resources