

Notary Public

DREXEL UNIVERSITY Statement of Termination of Domestic Partnership COLLEGE OF MEDICINE

Employee Last Name	Employee First Name	Employee Middle Initial/Name
Domestic Partner Last Name	Domestic Partner First Name	Domestic Partner Middle Initial
I, the above employee, hereby declare that my dome understand that: - Benefits and perquisites provided under any bei ("Drexel Med") shall terminate as of the date here continue to be my tax qualified dependents.	nefit programs sponsored by Drexel Uni	versity College of Medicine
-My former domestic partner and any of his or he result of the termination of my domestic partners coverage (i.e. COBRA coverage) under Drexel Med prevailing University rates plus a 2% administration	ship will be offered the opportunity to e d benefit programs. The rates for contin	lect health care continuation
-The termination of my domestic partnership will programs. If my former domestic partner is name beneficiary on forms provided by the University's	ed as my beneficiary under any benefit p	•
-In the event we resume our domestic partnershi again until I complete and satisfy the requiremen		
-That Drexel Med will send a copy of this form to	my former domestic partner.	
Employee Signature		Date
Sworn to and subscribed before me this day of,		
Notary Public		My Commission Expires