

Statement of Termination of Domestic Partnership

Return this form to HR-Benefits after signing in the presence of a Notary Public. Alternatively, you may sign this form in the presence of a representative of the Office of Human Resources. The Office may be contacted by e-mail (ben-serv@udel.edu) or phone (302 831-2171) with any questions about this form or your benefits.

Employee Last Name, First Name, Middle Initial

Employee ID

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 the University of Delaware (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/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 continuation of dental or vision 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 any health care coverage provided under the State of Delaware employee health insurance plan will be pursuant to the terms and conditions of such coverage and is not included in the University's extension of benefits to same sex partners.
- 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 Office of Human Resources.
- 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*.
- I will send a copy of this form to my former domestic partner.

Employee's Signature

Date

Signature, Office of Human Resources Representative

Date

OR

Notary Public

Subscribed and Sworn to before me this _____ day of _____, 200____

My commission expires: _____