JOHNS HOPKINS
U N I V E R S I T Y

School of Medicine

MARRIAGE/DOMESTIC PARTNERSHIP TERMINATION FORM

I, _____ have terminated my marriage/domestic partnership with
Name of subscriber (print)

_____
Name of former spouse/domestic partner (print)

The date that our marriage/domestic partnership terminated was _____/____/_____
MM/DD/YYYY

Under penalty of perjury, I affirm that I will mail a copy of this completed termination statement to my former spouse/domestic partner.

Subscriber Signature: _____ Date: _____

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), we are required to notify your former spouse this his/her insurance coverage has ended and that he/she is eligible for extended insurance benefits. Please provide a forwarding address in the space below for your former spouse/domestic partner.

_____
Street Address including apartment/unit number if applicable

_____
City, State, Zip Code

Return this completed form to:

Johns Hopkins University School of Medicine
Office of the Registrar, Benefits Desk
Miller Research Building, suite 147
Baltimore, MD 21205-2196