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

School of Medicine

MARRIAGE/SAME-SEX DOMESTIC PARTNERSHIP TERMINATION FORM

Please Print

I, _____ SSN _____-_____-_____ ,
Name of subscriber

Have terminated my marriage/same-sex domestic partnership with

_____ SSN_____-_____-_____,
Name and SSN of former spouse/domestic partner

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/same-sex domestic partner.

_____
Street Address including apartment/unit number if applicable

_____
City, State, Zip Code

Return this completed form by mail or fax to:

Johns Hopkins University School of Medicine
Office of the Registrar, Attention Benefits
Miller Research Building suite 147
Baltimore, MD 21205-2196
Fax: 410-955-0826