

## Statement of Termination of Same-Sex Domestic Partnership

I, \_\_\_\_\_ (Employee) and/or I, \_\_\_\_\_ (Former Named Partner), attest and declare that \_\_\_\_\_ (Former Named Partner) and I are no longer same-sex domestic partners as of \_\_\_\_\_ (date).

I/We understand that coverage for this former same-sex domestic partner will end on the last day of the month during which the domestic partnership is terminated. No COBRA will be offered.

I make and file this Statement of Termination of Same-Sex Domestic Partnership in order to cancel the Same-Sex Domestic Partner Statement filed by me on \_\_\_\_\_ (date) because we no longer meet the requirements of same-sex domestic partnership as set forth in the Same-Sex Domestic Partner Statement. Receipt by TeamHealth of this Statement of Termination of Same-Sex Domestic Partnership shall be deemed conclusive evidence of the termination of the same-sex domestic partnership status.

I as an employee of TeamHealth, understand that another Same-Sex Domestic Partner Statement cannot be filed until twelve (12) months after the date set forth above.

Employee Signature \_\_\_\_\_

Named Partner Signature \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_