

Statement of Termination of Spousal Equivalency

SECTION 1 - Notification of Termination

I, _____, notify Northeastern University that the Same Sex Spousal Equivalency Certification attested to and signed by me and

_____ was terminated as of _____
Name of Spousal Equivalent Date

and I have sent a copy of this signed Statement to my aforesated spousal equivalent.

I will also complete the necessary forms required by my health/dental plan to change my coverage within the required time limits for making a change in coverage due to a change in family status.

SECTION 2 - Notification to Former Spousal

I mailed a signed copy of this form to my former spousal equivalent on _____
Date Mailed

My former spousal equivalent's mailing address is: _____

SECTION 3 - Signature

I declare that the above statements are true and correct.

Signature of Employee

Date Signed

Employee's Social Security Number

Former Spousal Equivalent's Social Security Number

SECTION 4 - Health/Dental Plan Change Forms

Health/Dental Plan Enrollment Forms Completed

Name of Health Plan

Date Form Filed with Benefits

Dental Plan

Date Form Filed with Benefits