TERMINATION OF DOMESTIC PARTNERSHIP STATEMENT

I, ____, hereby notify Nortel
Name of Employee (Print)

(the "Company") that ____
Name of Domestic Partner (Print)

(Social Security number: _________________________) ceased to be my domestic partner

as of ___________________________.
Date

I understand that my domestic partner and/or domestic partner's children will cease to participate in and/or be covered by any applicable Company plans, programs or procedures as of the aforementioned date or, in the case of any applicable health coverage, the end of the month in which our partnership ceased to exist, and am aware that the Company has no duty to provide notice of this termination to my domestic partner and/or domestic partner's children. If I selected health coverage for my domestic partner and/or domestic partner's children under FLEX benefits, I acknowledge that I can change this option within thirty-one (31) days of the termination of our partnership by filing this statement. Further, I acknowledge that, if I fail to file the Termination of Domestic Partnership Statement within thirty-one (31) days, said coverage will still cease at the end of the month in which the event occurred. There will be no reimbursement of premiums paid for periods prior to notifying Nortel of the event and the completion of the related event changes, even though the domestic partner and/or domestic partner's children will not have been eligible for coverage. Nortel may also pursue legal action against you and your domestic partner to recover benefits paid on behalf of your former domestic partner and /or domestic partner's children after the termination of your domestic partnership if you do not notify Nortel of the termination within 31 days. I understand that my domestic partner and/or domestic partner's children will have COBRA election rights by which any applicable health coverage may be continued. However, if I fail to contact HR Shared Services within sixty (60) days of the termination of domestic partnership, my domestic partner and/or domestic partner's children will not be eligible for COBRA.

Further, I understand that I cannot submit another Affidavit of Domestic Partnership ("Affidavit") for twelve (12) months following the receipt of this document by HR Shared Services nor can I be listed as a domestic partner on such an Affidavit during that period.

_________________________ ____
Signature of Employee Employee's Social Security #

_________________________ ____
Employee's Global ID Employee's Work Phone#

Please keep a photocopy of this document for your records. Return the ***original*** completed form to: HR Shared Services, Department 7094, Mail Stop 570020C2, PO Box 13010, Research Triangle Park, NC 27709-3010. If you have questions, please call HR Shared Services at ESN 355-9351, 919-905-9351, or 1-800-676-4636.