



## NOTICE OF RETURN TO WORK

**Instructions - This form should be completed by the employer and sent the same day the employee returns to work after receiving disability benefits.**

Contract/Group no.	Account/Division no.	Certificate no.	Name of employee
Date of return to work YYYY MM DD  _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _		Time  _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _  <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Basis <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

If the employee was able to resume work at an earlier date, but did not report due to lack of work of or other reasons, give date work could have been resumed and a full explanation. (Use extra sheet, if necessary).

---



---

Date

Name of policyholder

**Authorized signature of employer**

