Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

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GROUP INSURANCE - DISABILITY CLAIMS

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.

Policy/group/contract no.	Account or division no.	Certificate or identification no.	Last name and first name of employee

Date of return to work
YYYY MM DD

Time
☐ A.M.
☐ P.M.

Basis
☐ Full-time
☐ 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

Last name and first name of the authorized person (PLEASE PRINT)

Signature