

Return to Work Notice

IDENTIFICATION									
Na	ame of Insured:						Policy No.:		
IN	NFORMATION ON	RETURN TO V	WORK						
1.	Return to work da	te:da	ay/month/yea	r					
2.	Is it the same posit				es 🗖 no				
3.	Is it a graduated return to work: □ yes □ no If yes, please specify: • Number of hours per week prior to disability: • Number of hours recommended by your doctor, per week: From:								
				day/month/year day/month/year					
	From:day	/month/year	to:	day/month/year		hours			
	From:day	/month/year	to:	day/month/year		hours			
C	OMMENTS								
			 						
ST	TATEMENT								
I hereby certify that the above information is, to the best of my knowledge, true and complete.									
								d	ay/month/year
Si	ignature							Date	ay/month/year