



Desjardins
Insurance

LIFE • HEALTH • RETIREMENT

C. P. 3875 succ. Lévis
Lévis (Québec) G6V 0A7
Fax: 418-835-0194
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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	Basis
<input type="text"/>		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
<p>If the employee was able to resume work at an earlier date, but did not report due to lack of work or other reasons, give date work could have been resumed and a full explanation. Use extra sheet, if necessary.</p> <hr/> <hr/>			
Date		Name of policyholder	
Last name and first name of the authorized person (PLEASE PRINT)		Signature	