

Return to Work Notice

IDE	ITIFICATION
Nar	e of Insured:Policy No.:
INF	DRMATION ON RETURN TO WORK
	Return to work date:day/month/year
١.	day/nonny/ea
2.	s it the same position that you had prior to your disability: yes no fno, please provide details in the Comments section.
3.	s it a graduated return to work: yes no yes, please specify: Number of hours per week prior to disability: Number of hours recommended by your doctor, per week: From: day/month/year to:day/month/year, hours
	From: day/month/year to: day/month/year hours
	From: day/month/year to: day/month/year hours
	From:day/month/yearto:day/month/year,hours
I hereby certify that the above information is, to the best of my knowledge, true and complete. By sending us this form, you understand that we will process your personal information in accordance with the terms of our Privacy Policy. We invite you to read our Privacy Policy available on our web site, which provides, without limitation, information about the categories of third parties to whom it is necessary to communicate and/or to obtain your personal information, sometimes outside your province of residence, and your rights to access and correct your personal information.	
Sic	ature Date