the co-operators
A Better Place For You™

# NOTICE OF RETURN TO WORK

# CLAIM FOR GROUP DISABILITY BENEFITS

This form should be completed by the employer when the employee returns to work and mailed immediately to:

The Co-operators Life Insurance Company
1920 College Avenue
Regina, Saskatchewan
S4P 1C4
Attention: Group Claims

Name of employee ____________________________________________
(Please Print)

This employee returned to work on ______________________ , __________
following absence due to disability.

Group Policy Number ____________________

Account Number ____________________

Certificate (PID) Number ____________________

Name of employer ____________________________________________
(Please Print)

Signed by ____________________________________________

Official title ____________________________________________

Telephone # ______________________________

Date ______________________ , __________