the co-operators
A Better Place For You®

GROUP BENEFITS RETURN TO WORK NOTICE

FOR OFFICE USE ONLY

MAILING ADDRESS

Mail: Co-operators Life Insurance Company
Disability Claims Department
1920 College Avenue
Regina SK S4P 1C4

Fax: 1-866-889-9926

INSTRUCTIONS

This form should be completed when the plan member returns to work.

1. PLAN MEMBER INFORMATION

Plan Member ______________________ ____ ______________________
First Name Initial Last Name

Group ______________ Account ______________ Certificate ______________

Date returned to work ______________
MMM/DD/YYYY

2. DECLARATION

Name of Plan Sponsor ______________________________

Phone Number (_____)______________ Cell Number (______)______________ Fax Number (______) ______________

Name of Supervisor ______________________________ Phone Number (______) ______________

Address ______________________ ______________ ________ ________
Street City Province Postal Code

Form completed by ______________________________ Title ______________
Name (please print)

I hereby declare that the answers to the above questions are accurate and complete.

Authorized Signature ______________________________ Date ______________
MMM/DD/YYYY

Co-operators Life Insurance Company Privacy Statement
Co-operators Life Insurance Company is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.