HUMANIA ASSURANCE MD®

Notice of return to work

This form has to be sent to the insurance Company by the Employer as soon as possible after the Employee recovers.

This is to inform you that: _____

(Name of employee)

Insured under policy no.: _____ certificate no.: _____

Returned to work on: _____ 20 _____

Having recovered from this recent disability, on _____ 20 _____

(Last day of actual total disability)

_____

Signature of employer

Date : _____ 20 _____ By: _____

According to attending physician's statement, the employee should return to work on: _____ 20 _____

N.B. If still disabled after this date, please submit a continuation of disability report

Claims Department by: _____