HUMANIA ASSURANCE MD®

Employer's confirmation
Gradual Return to Work

Identification

Employee's name: _____

Policy no.: _____ Claim no.: _____

Please complete the following form at the end of the identified period by indicating the **number of worked hours** per day. To prevent any further delays in issuing the disability benefit payment, please make sure to transfert the present form as soon as the period is over.

Month of: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Gross total amount paid for the month: _____

Present gross hourly rate: _____

Has the employee received any vacation or holiday pay? ☐ Yes ☐ No

Was the vacation pay accumulated during disability? ☐ Yes ☐ No

If so, please indicate the gross amount paid for vacation: _____ for holidays: _____

Scheduled date of the full time return to work: _____

Signature: _____

Name (please print): _____

Phone number: _____ Date: _____

Please return this form by fax at **1 877-660-2519** or email at **claims@humania.ca**. For more information, do not hesitate to contact our customer service department at 1 877-987-3076. Our representatives will be happy to answer your questions.

4300-004-en
2017/05