MUTUAL

NOTICE OF RETURN TO WORK
GROUP INSURANCE

NAME OF INSURED	CERTIFICATE NUMBER

DATE OF RETURN TO WORK ____ ____ ____ ____

TIME _____ A.M ☐ P.M ☐

HAVE YOU RETURNED TO YOUR REGULAR OCCUPATION ? YES ☐ NO ☐

IF NO, STATE OCCUPATION _____

IF YES FULL-TIME ☐ PART-TIME ☐

IF PART-TIME, GIVE REASON : _____

_____

_____

X

DATE **SIGNATURE**

566-A (11-12)

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566-A (11-12)