



STATUS ON RETURN OF ABSENT EMPLOYEE

Completed by the Employer or Plan Administrator. This form is required when an employee returns to work after a disability related absence. It is NOT required if the date of return to work is shown on the last claim form. However, this form is NOT to be completed before the employee actually returns to work. Incomplete responses or missing information will cause delays in the assessment and handling of this file.

Name of Employee: _____
(First) (Last)

Policy Number: _____ Certificate Number: _____ Claim Number: _____

1. The above named employee returned to their full duties and work hours on: Date: _____
at _____ a.m. _____ p.m., having been absent on account of _____
(sickness or accident)

2. If employee was able to resume full work duties at an earlier date but did not report due to lack of work or for other reasons, give date work could have been resumed and full explanation.

3. If employee has not returned to work and is no longer with your company, please indicate the termination date.

Name of Employer/Plan Administrator (please print)

Date: _____ By _____
Authorized Signature of Employer/Plan Administrator

Upload the signed and completed form via www.equitablehealth.ca using our secure Document Submission Tool located under the Quick Links section. You can also fax them to 1.888.505.4373 or mail them to:

Equitable Life of Canada
Group Disability Claims Department
One Westmount Road North
P.O. Box 1603 Stn. Waterloo, Waterloo Ontario N2J 4C7

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