



## RETURN TO WORK NOTICE

Dear Policyholder:

Please complete this return to work notice for claimant mentioned below and return this form to First Rehabilitation Life.

POLICY # \_\_\_\_\_ CLAIM # \_\_\_\_\_

DISABLED EMPLOYEE \_\_\_\_\_

RETURNED TO WORK ON \_\_\_\_\_ AT \_\_\_\_\_  
(DATE) (TIME)

BECAME DISABLED AGAIN ON: \_\_\_\_\_  
(DATE)

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE COMPLETE AND  
RETURN TO:**

**First Rehabilitation Life - Claims Dept.  
600 Northern Blvd.  
Great Neck, New York 11021-5202**