PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

RETURN TO WORK NOTICE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-8099

Please complete this form the day the employee returns to work after claiming DISABILITY BENEFITS.
Mail or fax completed form immediately to British Columbia Life & Casualty Company at the above address.

MEMBER INFORMATION

Type of claim

☐ Short term disability ☐ Long term disability ☐ Waiver of premium

Employee's first name	Employee's last name

Group number	ID number	Date returned to work (mm-dd-yyyy)

Remarks

Employer's name

Authorized official's signature **X**	Date (mm-dd-yyyy)

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