



**PreDisability Vocational Coaching Referral Form**

PLEASE COMPLETE AND RETURN VIA FAX OR EMAIL TO:

Fax: 860.731.3049 | Email: [PreDisability@NewYorkLife.com](mailto:PreDisability@NewYorkLife.com)

Please also have the employee sign the Authorization to Release Information Form and submit along with this form.

TO BE COMPLETED BY THE EMPLOYER			
Employee Last Name	Employee First Name	MI	Employee Phone Number
Employee Occupation		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary	Date of Birth
Company Name			
Street Address (Employee's Work Location)			
City		State	Zip
Employee Work Email			
Please check the appropriate blocks regarding the employee's employment and benefit status <input type="checkbox"/> Enrolled in GBS fully insured LTD coverage <input type="checkbox"/> No LTD Coverage <input type="checkbox"/> Enrolled in GBS FMLA/ADA Services			
Reason for Referral			
Is this injury or illness subject to a pending, active, or in-appeal Workers' Compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the employee aware that you are making this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will a signed authorization be provided at the time of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the employee lost any time from work due to reason for referral: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much	
Referring Person's Name	Referring Person's Email	Date of Referral	
Referring Person's Title		Referring Person's Phone	
Contact Person's Name	Contact Person's Title	Contact Person's Phone	