

PreDisability Vocational Coaching Referral Form

PLEASE COMPLETE AND RETURN VIA FAX OR EMAIL TO: Fax: 860.731.3049 | Email: <u>PreDisability@NewYorkLife.com</u>

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 | Employe | ee First Name | MI | Employee Ph | one Number | |
| Employee Occupation | | | Gender 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 Enrolled in GBS fully insured LTD coverage No LTD Coverage 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? 🔲 Yes 🔲 No | | | | | | |
| Is the employee aware that you are making this referral? 🔲 Yes 🔄 No | | | | | | |
| Will a signed authorization be provided at the time of the referral? | | | | | | |
| Has the employee lost any time from work due to reason fo Yes No | | | | eferral: | If yes, how much | |
| | | | | | | |
| Referring Person's Name Referring Person's | | | Emai | | | |
| Referring Person's Title | | | Referring Person's Phone | | | |
| Contact Person's Name | | Contact Person's Title | | | Contact Person's Phone | |

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