

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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