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GROUP INSURANCE - DISABILITY CLAIMS

## PEBT JEIS REFERRAL FORM POLICY 64090L

<b>School district no.</b>	<b>Union affiliation</b>	<b>Date</b>	YYYY	MM	DD
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**From:** **Name of Absence Advisor**

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**Address**

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<b>Phone number</b>	<b>Fax number</b>
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**Email address**

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**c.c.:**

### EMPLOYEE INFORMATION

<b>Last name and first name</b>	<b>Sex</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of birth</b>	YYYY	MM	DD
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**Mailing address**

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**Email address**

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<b>Home phone number</b>	<b>Cell-phone number</b>
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<b>Last day worked</b>	YYYY	MM	DD	<b>Date of hire</b>	YYYY	MM	DD
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**Occupation**

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<b>Hours per week</b>	<b>Months per year</b>	<b>Effective date of coverage</b>
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<b>Employee number</b> (school district no. (e.g. 36) + employee no.)	<b>Worksafe claim</b>
	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Pending

### COMMENTS

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