

BCPVPA BENEFITS PLAN EIP REFERRAL FORM

Client Information:

Name: _____

School District: _____

Position: _____

Preferred Method of Communication:

Phone Fax Email Text

Date of Birth: (dd/mm/yyyy): _____

Home Address: _____

I am a BCPVPA Benefits Plan Member: Yes No I don't know

Additional comments: _____

Date: _____

School / Facility: _____

Office Phone: _____

Mobile / Personal Phone: _____

Preferred Email: _____

Employment Status:

Working FT Sick Leave

Working PT STD

Working Reduced
Assignment LTD

Third-Party Referrals:

*** Submitted on behalf of and with consent of member, by:**

BCSSA / BCPVPA District Association Representative District Representative

Name and title: _____

Additional comments: _____

Internal Use:

BCPVPA LTD Benefits Plan Number: _____

Internal Referral Number: _____

Date Received: _____

PN Set Up By: _____

Assigned RC: _____

Please save a copy of this form to your desktop, fill it in & email

OR,

Print off and send to:

humanworks head office

Phone: +1 604-734-4130

Fax: +1 604-298-0266

email: admin@humanworks.ca


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