Culinary Workers Health Fund

LOSS OF TIME BENEFITS CHECKLIST

This is a checklist to guide you with your Loss of Time benefits. Your benefits will be delayed if documents are not accurate and complete.

- ✓ ALL Loss of Time benefits are limited to a maximum of 13 weeks.
- ✓ PART 1 – must be completed by your employer. Please have your Human Resources Dept (not your supervisor) complete the form.
- ✓ PART 2 – must be completed by your doctor, **not including PhDs** (see SPD for definition of doctor on page 131).
- ✓ Parts 1 and 2 must be completed and returned to us to process your claims.
- ✓ The dates of disability on parts 1 and 2 should be within the same time frame.
- ✓ Please make sure all forms are **COMPLETE.**
- ✓ Illness and injury benefits will not begin until you are treated, seen and disabled by your doctor.
- ✓ Injury benefits begin the 1st day of disability leave **(includes maternity benefits for delivery)**.
- ✓ Illness benefits begin the 8th day of disability leave.
- ✓ A report must be submitted if illness/injury involves police or security.
- ✓ If you are returned to work for light duty only, and light duty is not available through your employer, your doctor should continue your leave dates. A verification letter from your employer may be required.
- ✓ **If your leave dates change after the forms are submitted, new forms will be required. Please submit forms as close as possible to your leave date.**
- ✓ We do not pay loss of time on work related conditions.
- ✓ Loss of Time benefits is a weekly payment of $150 less FICA taxes, which equals to $138.52.

LOSS OF TIME – PART 1

HOTEL EMPLOYEES AND RESTAURANT EMPLOYEES INTERNATIONAL UNION WELFARE FUND

Please be advised that possession of this form is not evidence of eligibility.
Loss of Time benefits are explained on your SPD.

INSTRUCTIONS: THIS IS FORM 1 OF 2 FOR LOSS OF TIME BENEFITS. EMPLOYEE COMPLETES AND SIGNS THIS SECTION, THEN GIVES FORM TO EMPLOYER.

Name of Employee _____ Date of Birth _____

Social Security No. _____ Occupation _____ Local No. _____

Language Preference ☐ English ☐ Spanish ☐ Other _____ E-mail Address _____

Home Address _____
STREET CITY OR TOWN STATE ZIP PHONE NUMBER

Nature of illness or injury _____

Date of accident occurred or illness/injury began _____ Date first treated _____

How did illness/injury occur? _____
If illness/injury involves police or security, please attach report.

Where did illness/injury occur? _____

Did illness/injury occur in the course of any employment: ☐ NO ☐ YES → If YES, you must file a claim with your employer.

Name and address of Physicians consulted 1) _____
2) _____

If HOSPITALIZED,
Name of hospital _____ Admitted _____ Discharged _____

AUTHORIZATION TO RELEASE INFORMATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I authorize my employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund with financial or employment related information.

I understand that such information may be used by the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency, or independent administrator acting on its behalf, for all purposes related to evaluating, processing, and reviewing my claim for benefits, including examining the benefits provided by the H.E.R.E.I.U. Welfare Fund. I understand that I or any authorized representative will receive a copy of the authorization upon request. This authorization is valid for a minimum of one year.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____

Signature of Employee *(Employee MUST sign form)* Date

EMPLOYER'S STATEMENT (PAYROLL DEPARTMENT)

Employee's Name: _____

Social Security Number: _____ Last physical day employee worked: _____
mm / dd / yy

Has Employee Returned to Work? ☐ YES → If YES, Date Returned to Work: _____ Employee Number: _____
mm / dd / yy

☐ NO → If NO, Date Expected to Return to Work: _____
mm / dd / yy

Has a Worker's Compensation Claim Been Filed for this Illness/Injury? ☐ NO ☐ YES

Employer's Name: _____ E-mail Address: _____

Address: _____

Human Resources Dept. Signature: _____

Title: _____ Date: _____

RETURN COMPLETED FORM TO:

CULINARY WORKERS HEALTH FUND
1901 LAS VEGAS BLVD. SOUTH SUITE 107 LAS VEGAS NV 89104-1309
(702) 733-9938 www.culinaryhealthfund.org

LOSS OF TIME – PART 2

HOTEL EMPLOYEES AND RESTAURANT EMPLOYEES INTERNATIONAL UNION WELFARE FUND

Please be advised that possession of this form is not evidence of eligibility.

INSTRUCTIONS: THIS IS FORM 2 OF 2 FOR LOSS OF TIME BENEFITS. EMPLOYEE COMPLETES AND SIGNS THIS SECTION, THEN GIVES FORM TO DOCTOR.

Name of Employee _____ Date of Birth _____

Social Security No. _____ Phone Number _____

Home Address _____
STREET CITY OR TOWN STATE ZIP

AUTHORIZATION TO RELEASE INFORMATION

Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency or independent administrator acting on its behalf, information concerning advice, care or treatment provided the patient, employee or deceased named below, including information relating to mental illness, use of drugs or use of alcohol. I authorize my employer or benefit plan administrator to provide the H.E.R.E.I.U. Welfare Fund with financial or employment related information.

I understand that such information may be used by the H.E.R.E.I.U. Welfare Fund or an agency, attorney, claims investigative agency, or independent administrator acting on its behalf, for all purposes related to evaluating, processing, and reviewing my claim for benefits, including examining the benefits provided by the H.E.R.E.I.U. Welfare Fund. I understand that I or any authorized representative will receive a copy of the authorization upon request. This authorization is valid for a minimum of one year.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____

Signature of Employee *(Employee MUST sign)* Date

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____

Diagnosis: _____

Is Condition Due to Illness or Injury Arising from Patient's Employment? ☐ NO ☐ YES

Is Condition Due to Accident? ☐ NO ☐ YES

Is Condition a Behavioral Health Condition? ☐ NO ☐ YES (REMINDER: form must be signed by an MD)

Date of First Treatment: _____ Dates of Subsequent Treatments: _____
mm / dd / yy (mm / dd / yy) *(patient must be under regular continuous care of MD)*

Patient has been Unable to Work Since: _____ Expected Return to Work Date: _____
mm / dd / yy mm / dd / yy

If Disabled Due to Pregnancy, Give Expected Date of Confinement: _____
mm / dd / yy

Surgical Procedure Performed: _____

Date of Surgery: _____
mm / dd / yy

Are there any Complications that have Delayed Return to Work? ☐ NO ☐ YES → If YES, Please be specific (office notes may be requested):

_____

Can this employee currently perform the regular duties of his/her job? ☐ NO ☐ YES → If NO, is the inability to perform the job duties ☐ Permanent ☐ Temporary

Patient released for: ☐ light duty → after _____ weeks ☐ full duty → after _____ weeks

Please Print Physician's Name: _____ Phone No. _____

Address: _____ Fax No. _____

I hereby certify that all information provided on this form is accurate to the best of my knowledge.

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

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