Culinary Health Fund™

1901 Las Vegas Blvd. So. Suite 107
Las Vegas, Nevada 89104-1309
(702) 733-9938
www.culinaryhealthfund.org

ADMINISTRATIVE OPEN ENROLLMENT FORM

PARTICIPANT INFORMATION:

FULL NAME (LAST, FIRST, MI):			SSN:
DOB:	GENDER: ☐ MALE ☐ FEMALE	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED/SEPARATED	
ADDRESS, CITY, STATE, ZIP:			
TELEPHONE:	EMAIL:		
LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ OTHER ___________________________________			LOCAL UNION:
EMPLOYER NAME:	JOB CLASS:		DATE OF HIRE: ____/____/______

DEPENDENT INFORMATION (You must provide original or certified copy of proof of relationship such as marriage and/or birth certificate, etc.):

LAST NAME	FIRST NAME - MIDDLE INITIAL	DATE OF BIRTH	GENDER	SSN	RELATION TO PARTICPANT	ADULT CHILD
			☐ MALE ☐ FEMALE		SPOUSE; DATE OF MARRIAGE: _____/____/_______	
			☐ MALE ☐ FEMALE		DEPENDENT CHILD	☐
			☐ MALE ☐ FEMALE		DEPENDENT CHILD	☐
			☐ MALE ☐ FEMALE		DEPENDENT CHILD	☐
			☐ MALE ☐ FEMALE		DEPENDENT CHILD	☐
			☐ MALE ☐ FEMALE		DEPENDENT CHILD	☐

SPOUSE INFORMATION (In the event of divorce you must notify the Culinary Health Fund):

SPOUSE WORKS? ☐ YES ☐ NO	IS INSURANCE OFFERED? ☐ YES ☐ NO	IF NO, REASON: ☐ INSURANCE NOT OFFERRED ☐ ELIGIBLE NOT ENROLLED ☐ PART TIME EMPLOYEE ☐ NEW EMPLOYEE ELIGIBLE ___/____/______
EMPLOYER NAME:		INSURANCE TYPE: ☐ SINGLE ☐ FAMILY

ADULT DEPENDENT INFORMATION:

NAME:		
ADULT DEPENDENT WORKS? ☐ YES ☐ NO	IS INSURANCE OFFERED? ☐ YES ☐ NO	IF NO, REASON: ☐ INSURANCE NOT OFFERRED ☐ ELIGIBLE NOT ENROLLED ☐ PART TIME EMPLOYEE ☐ NEW EMPLOYEE ELIGIBLE ___/____/______
EMPLOYER NAME:		INSURANCE TYPE: ☐ SINGLE ☐ FAMILY
SIGNATURE:		

NAME:		
ADULT DEPENDENT WORKS? ☐ YES ☐ NO	IS INSURANCE OFFERED? ☐ YES ☐ NO	IF NO, REASON: ☐ INSURANCE NOT OFFERRED ☐ ELIGIBLE NOT ENROLLED ☐ PART TIME EMPLOYEE ☐ NEW EMPLOYEE ELIGIBLE ___/____/______
EMPLOYER NAME:		INSURANCE TYPE: ☐ SINGLE ☐ FAMILY
SIGNATURE:		

NAME:		
ADULT DEPENDENT WORKS? ☐ YES ☐ NO	IS INSURANCE OFFERED? ☐ YES ☐ NO	IF NO, REASON: ☐ INSURANCE NOT OFFERRED ☐ ELIGIBLE NOT ENROLLED ☐ PART TIME EMPLOYEE ☐ NEW EMPLOYEE ELIGIBLE ___/____/______
EMPLOYER NAME:		INSURANCE TYPE: ☐ SINGLE ☐ FAMILY
SIGNATURE:		

NAME:		
ADULT DEPENDENT WORKS? ☐ YES ☐ NO	IS INSURANCE OFFERED? ☐ YES ☐ NO	IF NO, REASON: ☐ INSURANCE NOT OFFERRED ☐ ELIGIBLE NOT ENROLLED ☐ PART TIME EMPLOYEE ☐ NEW EMPLOYEE ELIGIBLE ___/____/______
EMPLOYER NAME:		INSURANCE TYPE: ☐ SINGLE ☐ FAMILY
SIGNATURE:		

OTHER INSURANCE INFORMATION (LIST ANY OTHER INSURANCE INCLUDING MEDICARE/MEDICAID):

PERSON(S) COVERED	OTHER INSURANCE NAME	EFFECTIVE DATE	POLICY NUMBER	INSURANCE TYPE
				☐ MEDICAL ☐ SINGLE ☐ DENTAL ☐ FAMILY
				☐ MEDICAL ☐ SINGLE ☐ DENTAL ☐ FAMILY

CONSENT INFORMATION:

By my signature below, I acknowledge that the Culinary Health Fund and its authorized agents may use and disclose health information for purpose related to evaluating, processing and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the Culinary Health Fund by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan Administrator.

This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Culinary Health Fund's plan of benefits.

I understand and agree that any intentional omissions or incorrect statements made on this form may result in the termination of my and/or my dependents health benefits.

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

____ Signature

____________________ Date

1901 Las Vegas Blvd. South Suite 107
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Culinary Health Fund (UNITE HERE HEALTH)
PLAN 150 LIFE INSURANCE BENEFICIARY DESIGNATION FORM

PARTICIPANT/INSURED INFORMATION:

FULL NAME (LAST, FIRST, MIDDLE):		
DOB (MONTH/DAY/YEAR):	GENDER: ☐ MALE ☐ FEMALE	SSN:
ADDRESS, CITY, STATE, ZIP:		
TELEPHONE:	EMAIL:	

PRIMARY LIFE INSURANCE BENEFICIARIES

NAME (LAST, FIRST, MIDDLE):		SSN (if available):
DOB (MONTH/DAY/YEAR):	RELATIONSHIP:	SHARE OF BENEFIT: %
ADDRESS:		TELEPHONE:

NAME (LAST, FIRST, MIDDLE):		SSN (if available):
DOB (MONTH/DAY/YEAR):	RELATIONSHIP:	SHARE OF BENEFIT: %
ADDRESS:		TELEPHONE:

NAME (LAST, FIRST, MIDDLE):		SSN (if available):
DOB (MONTH/DAY/YEAR):	RELATIONSHIP:	SHARE OF BENEFIT: %
ADDRESS:		TELEPHONE:

SECONDARY LIFE INSURANCE BENEFICIARIES

(Please list who you want to receive your life insurance benefit in the event that your primary beneficiary[ies] listed above do not survive you.)

NAME (LAST, FIRST, MIDDLE):		SSN (if available):
DOB (MONTH/DAY/YEAR):	RELATIONSHIP:	SHARE OF BENEFIT: %
ADDRESS:		TELEPHONE:

NAME (LAST, FIRST, MIDDLE):		SSN (if available):
DOB (MONTH/DAY/YEAR):	RELATIONSHIP:	SHARE OF BENEFIT: %
ADDRESS:		TELEPHONE:

The amount of all shares must total 100%. If you name more than one beneficiary, but do not indicate the percent each beneficiary is to receive, the total amount paid will be divided equally amongst all surviving beneficiaries. If you name more than one primary beneficiary and one of them predeceases you, his or her share will be divided equally among the beneficiaries that survive you, unless you indicate otherwise. The same rule applies to your secondary beneficiaries.

Coverage is dependent upon the Plan's eligibility requirements and all Plan benefits are subject to the rules adopted by the Board of Trustees of the UNITE HERE HEALTH Fund. This form replaces all previous beneficiary designations. It must be signed and dated to be valid, and shall not become effective until received by the Culinary Health Fund Office.

Participant's/Insured's Signature: ____ **Date:** ________________________

Date Recorded (For Office Use Only)

RETURN COMPLETED FORM TO:

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

Culinary Health Fund

Private Health Survey

Employer Name: _____

What is your job title? _____

Would you like to receive text messages from the Culinary Health Fund?

☐ Yes ☐ No Cell: _____ Date: _____

Name: _____

DOB: _____ Sex: ☐ Male ☐ Female

SSN: _____

Address: _____

_____

Tel: _____ ☐ Home ☐ Cell

Email: _____

For You

1. **Have you ever had any other insurance?** ☐ Yes ☐ No If yes, what insurance? _____
2. **Do you have a regular doctor?** ☐ Yes, Dr. _____ ☐ No
3. **Do you smoke?** ☐ Yes ☐ No If yes, do you want to quit? ☐ Yes ☐ No
4. **Do you have any of these conditions:**

☐ Diabetes	☐ High Cholesterol	☐ Asthma/Allergies
☐ Heart Disease	☐ Kidney Problems	☐ Depression/Anxiety
☐ High Blood Pressure	☐ COPD (Emphysema)	☐ Cancer

5. **What medications are you taking?** _____
6. **Are you pregnant?** ☐ Yes ☐ No ☐ N/A Due date: _____ **Would you be interested in a breastfeeding class?** ☐ Yes ☐ No
7. **Select any of the tests that you have had:**

☐ Colon Cancer Screening (50+)	☐ Prostate (men 40+)
☐ Blood Test for Cholesterol	☐ PAP smear (women) Date (if known): _____
☐ Mammogram (Women) Date (if known): _____	☐ Osteoporosis Screening (women 65+)

For Your Spouse

Name: _____ **DOB:** _____ **Tel:** _____

1. **Have you ever had any other insurance?** ☐ Yes ☐ No If yes, what insurance? _____
2. **Do you have a regular doctor?** ☐ Yes, Dr. _____ ☐ No
3. **Do you smoke?** ☐ Yes ☐ No If yes, do you want to quit? ☐ Yes ☐ No
4. **Do you have any of these conditions:**

☐ Diabetes	☐ High Cholesterol	☐ Asthma/Allergies
☐ Heart Disease	☐ Kidney Problems	☐ Depression/Anxiety
☐ High Blood Pressure	☐ COPD (Emphysema)	☐ Cancer

5. **What medications are you taking?** _____
6. **Are you pregnant?** ☐ Yes ☐ No ☐ N/A Due date: _____ **Would you be interested in a breastfeeding class?** ☐ Yes ☐ No
7. **Select any of the tests that you have had:**

☐ Colon Cancer Screening (50+)	☐ Prostate (men 40+)
☐ Blood Test for Cholesterol	☐ PAP smear (women) Date (if known): _____
☐ Mammogram (Women) Date (if known): _____	☐ Osteoporosis Screening (women 65+)

For You, Spouse / Child:

Do you, your spouse or your child need help to lose weight?

☐ Self ☐ Spouse
☐ Child _____
☐ Child _____
☐ Child _____
☐ Child _____

Are there any other health conditions that you, your spouse or your child need help with? ☐ Self ☐ Spouse

☐ Child _____
☐ Child _____
☐ Child _____
☐ Child _____