LOSS OF TIME – PART 1

UNITE HERE HEALTH

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 UNITE HERE HEALTH 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 UNITE HERE HEALTH with financial or employment related information.

I understand that such information may be used by the UNITE HERE HEALTH 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 UNITE HERE HEALTH. 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: _____

Contact Name: _____ Phone Number: _____ E-Mail: _____

Human Resources Dept. Signature: _____

Title: _____ Date: _____

RETURN COMPLETED FORM TO:

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

PÉRDIDA DE TIEMPO – PARTE 1

UNITE HERE HEALTH

Por favor tenga en cuenta que la posesión de este formulario no comprueba la elegibilidad.
Los beneficios de Pérdida de Tiempo están explicados en su SPD.

INSTRUCCIONES: ESTE ES EL FORMULARIO 1 DE 2 PARA LOS BENEFICIOS DE PÉRDIDA DE TIEMPO. EL EMPLEADO COMPLETA Y FIRMA ESTA SECCIÓN Y LUEGO ENTREGA EL FORMULARIO A SU PATRÓN.

Nombre del Empleado _____ Fecha de Nacimiento _____

Núm. De Seguro Social _____ Ocupación _____ Núm. del Local _____

Preferencia de Idioma: ☐ Inglés ☐ Español ☐ Otro _____ Dirección de Correo Electrónico _____

Dirección _____
CALLE CIUDAD O PUEBLO ESTADO ZONA POSTAL TELÉFONO

Naturaleza de la enfermedad/lastimadura _____

Fecha del accidente o inicio de la enfermedad/lastimadura Fecha del tratamiento por primera vez _____

¿Cómo ocurrió la enfermedad/lastimadura? _____
Si la enfermedad/lesión compromete a la policía o a la seguridad, por favor incluya un informe.

¿En dónde ocurrió la enfermedad/lastimadura? _____

¿Ocurrió la enfermedad/lastimadura en el transcurso de cualquier empleo?: ☐ NO ☐ SI ➠ Si contestó "SÍ", usted tiene que presentar un reclamo a su Patrón.

Nombre y dirección de los Médicos consultados 1) _____
2) _____

SI ESTUVO HOSPITALIZADO,
Nombre del hospital _____ Admitido _____ Dado de alta _____

AUTORIZACIÓN DE DIVULGACIÓN DE INFORMACIÓN

Al presentar el original o fotostática de esta autorización firmada, yo autorizo que cualquier profesional médico, hospital u otra institución médica, organización de apoyo del seguro, farmacia, agencia gubernamental, compañia de seguros, grupo de asegurados, patrón o administrador del plan de beneficios proporcione al UNITE HERE HEALTH. o, a una agencia, abogado, agencia investigadora de reclamos o administrador independiente que actúe a nombre suyo, información sobre consejos, cuidados o tratamientos que se le proporcionen al paciente, empleado o difunto nombrado a continuación, incluyendo información relacionada a enfermedades mentales, uso de drogas o alcohol. Yo autorizo a mi patrón o al administrador del plan de beneficios que proporcione UNITE HERE HEALTH la información financiera o laboral relacionada.

Entiendo que el UNITE HERE HEALTH, o cualquier agencia, abogado, agencia de investigaciones de reclamos o administrador independiente que esté actuando a nombre suyo, podrá usar dicha información para todos los propósitos relacionados con la evaluación, procesamiento y revisión de mis reclamos de beneficios, incluyendo la evaluación de los beneficios proporcionados por el UNITE HERE HEALTH. Entiendo que yo o cualquier representante autorizado recibirá una copia de la autorización cuando sea solicitada. Esta autorización es válida por un mínimo de un año.

Yo por esto certifico que toda la información contenida en este formulario es precisa y completa a mi entender.

_____

Firma del Empleado *(El empleado DEBE firmar)* Fecha

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: _____

Contact Name: _____ Phone Number: _____ E-Mail: _____

Human Resources Dept. Signature: _____

Title: _____ Date: _____

DEVUELVA EL FORMULARIO COMPLETO A:

CULINARY 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

UNITE HERE HEALTH

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 UNITE HERE HEALTH 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 UNITE HERE HEALTH with financial or employment related information.

I understand that such information may be used by the UNITE HERE HEALTH 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 UNITE HERE HEALTH. 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: _____ ICD-9: _____

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)*

Date Medically Disabled by Physician: _____ 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:** _____

RETURN COMPLETED FORM TO:

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

PÉRDIDA DE TIEMPO – PARTE 2

UNITE HERE HEALTH

Por favor tenga en cuenta que la posesión de este formulario no comprueba la elegibilidad.

INSTRUCCIONES: ESTE ES EL FORMULARIO 2 DE 2 PARA LOS BENEFICIOS DE PÉRDIDA DE TIEMPO. EL EMPLEADO COMPLETA Y FIRMA ESTA SECCIÓN Y LUEGO ENTREGA EL FORMULARIO AL MÉDICO.

Nombre del Empleado _____ Fecha de Nacimiento _____

Núm. de Seguro Social _____ Teléfono _____

Dirección _____
CALLE CIUDAD O PUEBLO ESTADO ZONA POSTAL

AUTORIZACIÓN DE DIVULGACIÓN DE INFORMACIÓN

Al presentar el original o fotostática de esta autorización firmada, yo autorizo que cualquier profesional médico, hospital u otra institución médica, organización de apoyo del seguro, farmacia, agencia gubernamental, compañia de seguros, grupo de asegurados, patrón o administrador del plan de beneficios proporcione al UNITE HERE HEALTH o a una agencia, abogado, agencia investigadora de reclamos o administrador independiente que actúe a nombre suyo, información sobre consejos, cuidados o tratamientos que se le proporcionen al paciente, empleado o difunto nombrado a continuación, incluyendo información relacionada a enfermedades mentales, uso de drogas o alcohol. Yo autorizo al patrón o al administrador del plan de beneficios que proporcione al UNITE HERE HEALTH la información financiera o laboral relacionada.

Entiendo que el UNITE HERE HEALTH, o cualquier agencia, abogado, agencia de investigaciones de reclamos o administrador independiente que esté actuando a nombre suyo, podrá usar dicha información para todos los propósitos relacionados con la evaluación, procesamiento y revisión de mis reclamos de beneficios, incluyendo la evaluación de los beneficios proporcionados por el UNITE HERE HEALTH Entiendo que yo o cualquier representante autorizado recibirá una copia de la autorización cuando sea solicitada. Esta autorización es válida por un mínimo de un año.

Yo por esto certifico que toda la información contenida en este formulario es precisa y completa a mi entender.

_____

Firma del Empleado *(El empleado DEBE firmar)* Fecha

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____

Diagnosis: _____ ICD-9: _____

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)*

Date Medically Disabled by Physician: _____ 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:** _____

DEVUELVA EL FORMULARIO COMPLETO A:

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