MEDICAL/VISION
UNITE HERE HEALTH
Please be advised that possession of this form is not evidence of eligibility.
This side of form to be completed by the employee.

Name of Employee _____ Date of Birth _____

Social Security No. _____ Occupation _____

Home Address _____
Street City or Town State Zip Code

Home Phone Number _____ Employer's Name _____

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed Is Spouse Employed? ☐ Yes ☐ No

Name of Spouse _____ Spouse's S.S. # _____

Name and Address of Spouse's Employer _____

Are you, your spouse, or any of your other dependents insured under any other group insurance (including Culinary, student, accident or government plan)? No ☐ Yes ☐ If yes, complete A, B, C, D, E

A. NAME OF EMPLOYEE WITH COVERAGE _____ B. NAME OF DEPENDENT WITH OTHER COVERAGE _____

C. NAME OF INSURANCE COMPANY _____ D. POLICY NO. _____

E. ADDRESS OF INSURANCE COMPANY _____
No. & Street City State Zip Code

PLEASE COMPLETE IF ILLNESS OR INJURY IS DUE TO AN ACCIDENT OR EMPLOYMENT

Nature of Illness/Injury _____

Date Illness/Injury Occurred _____ Date of First Treatment _____

How did the Illness/Injury Occur? _____

Where did the Illness/Injury Occur? _____

Did Illness/Injury Ocur in the course of Employment? NO ☐ YES ☐ If YES, you must file a claim with your employer.

PLEASE COMPLETE IF CLAIM IS FOR DEPENDENT

Name of Dependent	Relationship to Employee	Date of Birth	Sex ☐ Male ☐ Female

If Child, is the child married?	Is Child employed?	If Child is 19 years or older, is child a full-time student?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes If yes, student verification from school required

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 policyholder, 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 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 or my dependent's claim for benefits, including examining the benefits provided by UNITE HERE HEALTH. I understand that I or any authorized representative will receive a copy of the authorization upon request. This authorization will be valid for the entire period of my eligibility and my dependent's eligibility under the UNITE HERE HEALTH plan of benefits.

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

AUTHORIZATION TO PAY BENEFITS

If this is for your vision benefit - please check one:

☐ payment should be sent to provider

☐ payment should be sent to participant

_____ _____
Signature of Employee or Other Authorized Person Date Relationship to Employee

This side of the form is to be completed by the Health Care Provider

NOTICE: PRIOR AUTHORIZATION MAY BE REQUIRED. PLEASE CONTACT UTILIZATION REVIEW ORGANIZATION FOR MORE INFORMATION

ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions (if diagnosis code other than ICD-9 used, provide name)			
2. Is condition due to injury/illness arising out of patient's employment?		No	Yes
3. Is condition due to an accident?	No	Yes	
4. Is condition related to pregnancy?	No	Yes	
5. Date patient first consulted you for this condition.		6. Patient ever had same or similar condition: No Yes If "YES", when and describe:	
7. Patient was continuously totally disabled (unable to work) From: Thru:		8. If still totally disabled, date patient should be able to return to work:	
9. Does patient have other health coverage? No Yes If "YES", please identify:			
PHYSICIAN'S NAME (PRINT)	TELEPHONE NO.	SOC. SEC. # OR TAX I.D. #	
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE
I HEREBY CERTIFY THAT ALL INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE Physician's Signature		Date	

PROVIDER: PLEASE ATTACH A STANDARD ITEMIZED BILL (SUCH AS UB92, UB82, SUPERBILL INVOICE OR HCFA 1500).

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

MÉDICA/VISIÓN
UNITE HERE HEALTH
Por favor tenga en cuenta que la posesión de este formulario no comprueba la elegibilidad.
El empleado debe completar este lado del formulario

Nombre del Empleado _____ Fecha de Nac. _____

de Seguro Social _____ Ocupación _____

Dirección _____
Calle Ciudad o Pueblo Estado Código Postal

Teléfono _____ Nombre del Empleador _____

Estado Civil ☐ Casado(a) ☐ Divorciad(a) ☐ Soltero(a) ☐ Viudo(a) Su esposo(a) está empleado(a)? ☐ Sí ☐ No

Nombre de su esposo(a) _____ Seg. Social del esposo(a) _____

Nombre y Dirección del Empleador del esposo(a) _____

Está asegurado usted, su esposo(a) o alguno de sus otros dependientes por algún otro seguro colectivo (incluyendo culinarios, seguro contra accidentes, para estudiantes, o plan del gobierno) ☐ No ☐ Sí Si contestó "sí" complete A, B, C, D, E

A. Nombre del empleado con otro seguro _____ B. Nombre del dependiente cubierto por otro seguro _____

C. Nombre de compañía de seguros _____ D. # de póliza _____

E. Dirección de la compañía _____
Núm. y Calle Ciudad Estado Código Postal

POR FAVOR COMPLETE LO SIGUIENTE SI LA ENFERMEDAD/LASTIMADURA SE DEBE A UN ACCIDENTE O SI OCURRIO EN EL TRABAJO

Naturaleza de la enfermedad/lastimadura _____

Fecha en que ocurrió _____ Fecha de su primer tratamiento _____

Cómo ocurrió? _____

Dónde ocurrió? _____

Ocurrió en el transcurso de su empleo? NO ☐ SÍ ☐ Si contestó "sí", usted tiene que presentar un reclamo a su empleador

POR FAVOR COMPLETE LO SIGUIENTE SI ESTA PRESENTANDO EL RECLAMO A NOMBRE DE UN DEPENDIENTE

Nombre del Dependiente	Parentezco con el participante	Fecha de Nacimiento	Sexo ☐ Masc. ☐ Fem.

Si es hijo/hija, está casado(a)?	Si es hijo/hija, está empleado(a)?	Si su hijo(a) tiene 19 o más de edad, es estudiante?
☐ No ☐ Sí	☐ No ☐ Sí	☐ No ☐ Sí Si contestó que sí, se requiere verificación de la escuela.

AUTORIZACIÓN PARA QUE SE COMUNIQUE INFORMACIÓN

Con la presentación del original o fotostática de esta autorización firmada, yo autorizo que cualquier profesional médico, hospital u otra institución médica, organización de apoyo de asegurados, farmacia, agencia gubernamental, compañia de seguros, grupo de asegurados, patrón o administrador del plan de beneficios proporcione 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 empleador o al administrador del plan de beneficios que proporcione a UNITE HERE HEALTH. la información financiera o laboral relacionada.

Entiendo que el Fondo de Bienestar H.E.R.E.I.U., o cualquier agencia, abogado, agencia de investigaciones de reclamos o administrador independiente que esté actuando de parte de ellos, podrá usar dicha información para todos los propósitos relacionados con la evaluación, procesamiento y revisión de mi reclamo, ó reclamo de mis dependientes para beneficios, incluyendo la evaluación de los beneficios proporcionados por el Fondo de Bienestar H.E.R.E.I.U. Entiendo que yo o cualquier representante autorizado recibirá una copia de la autorización cuando sea solicitada.

Esta autorización es válida por el periodo entero durante el cual yo y mis dependientes seamos elegibles bajo el Plan de Beneficios de UNITE HERE HEALTH.

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

AUTORIZACIÓN PARA PAGO DE BENEFICIOS

Si esto es para sus beneficios de visión - favor de marcar uno:

☐ el pago deberá enviarse al proveedor

☐ el pago deberá enviarse al participante

_____ _____ _____
Firma del Empleado u otra Persona Autorizada Fecha Parentezco de la Persona Autorizada

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