MEDICAL/VISION

HOTEL EMPLOYEES AND RESTAURANT EMPLOYEES INTERNATIONAL UNION WELFARE FUND

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

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 OTHER COVERAGE _____ B. NAME OF DEPENDENT WITH OTHER COVERAGE_____

C. NAME OF INSURNACE 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 of Illness/Injury Occurred _____ Date of First Treated _____

How Did Illness/Injury Occur? _____

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.

PLEASE COMPLETE IF CLAIM IS FOR DEPENDENT

NAME OF DEPENDENT	RELATIONSHIP TO EMPLOYEE	DATE OF BIRTH	SEX ☐ M ☐ F

IF CHILD, IS CHILD MARRIED?	IS CHILD EMPLOYED? ☐ NO ☐ YES	IF CHILD IS 19 YEARS OR OLDER, IS CHILD A FULL-TIME STUDENT?
☐ NO ☐ YES	☐ FULL-TIME ☐ PARTI-TIME	☐ 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 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 or my dependent's 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 will be valid for the entire period of my eligibility and my dependent's eligibility under the H.E.R.E.I.U. Welfare Fund's 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

(If Dependent Patient is under eighteen (18) years of age or is incapacitated, Parent or Guardian must sign)

_____
Relationship to Employee

THIS SIDE OF 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, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR 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 → IF "YES", APPROXIMATE DATE PREGNANCY COMMENCED:

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. NO. OR TAX I.D. NO.

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