

Culinary 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 the doctor that treated or is treating the injury or illness, **not including PhDs** (see SPD for definition of doctor).
- ✓ PART 2 – must be completed by your employer. Please have your Human Resources Department (not your supervisor) complete the form.
- ✓ 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 the same.
- ✓ 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

UNITE HERE HEALTH

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

INSTRUCTIONS: THIS IS FORM 1 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 _____	
<small>STREET</small>	<small>CITY OR TOWN</small>
<small>STATE</small>	<small>ZIP</small>

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

Date Medically Disabled by Physician: _____ (mm / dd / yy) Expected Return to Work Date: _____ (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

LOSS OF TIME – PART 2

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 2 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 <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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? _____	<i>If illness/injury involves police or security, please attach report.</i>				
Where did illness/injury occur? _____					
Did illness/injury occur in the course of any employment: <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> <i>If YES, you must file a claim with your employer.</i>					
Name and address of Physicians consulted	1) _____				
	2) _____				
If HOSPITALIZED, Name of hospital _____	Admitted _____	Discharged _____			

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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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If YES, Date Returned to Work: _____	Employee Number: _____
	mm / dd / yy	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If NO, Date Expected to Return to Work: _____	mm / dd / yy
Has a Worker's Compensation Claim Been Filed for this Illness/Injury? <input type="checkbox"/> NO <input type="checkbox"/> YES		
Employer's Name: _____	E-mail Address: _____	
Address: _____		
Contact Name: _____	Phone Number: _____	E-Mail: _____
Human Resources Dept. Signature: _____		
Title: _____	Date: _____	

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