

**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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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If Child, is the child married? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is Child employed? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Child is 19 years or older, is child a full-time student? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, student verification from school required</b>
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**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](http://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 OCURRIÓ 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	Parentesco con el participante	Fecha de Nacimiento	Sexo <input type="checkbox"/> Masc. <input type="checkbox"/> Fem.
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Si es hijo/hija, está casado(a)? <input type="checkbox"/> No <input type="checkbox"/> Sí	Si es hijo/hija, está empleado(a)? <input type="checkbox"/> No <input type="checkbox"/> Sí	Si su hijo(a) tiene 19 o más de edad, es estudiante? <input type="checkbox"/> No <input type="checkbox"/> Sí	Si contestó que sí, se requiere verificación de la escuela.
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**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, compañía 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 \_\_\_\_\_

Parentesco de la Persona Autorizada \_\_\_\_\_

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