HOSPITALITY PLAN
UNITE HERE HEALTH

Short-Term Disability Form

Updated: 1/1/22

ALL SECTIONS MUST BE SIGNED & FULLY COMPLETED!

Incomplete forms will not be accepted.

To avoid delay, please ensure all fields are completed.

Submit your form by:

Fax: 702-473-8108

Mail: 9121 W Russell Rd, Ste 219
Las Vegas, NV 89148

Email:
UNITEHEREDisability@zenith-american.com
(We're always careful with your personal information but email is not always private or secure. Please keep this in mind before emailing UNITE HERE HEALTH.)

FOR HELP, PLEASE CALL:

- **855-405-3863** or
- The number on the back of your medical ID card

STEP 1: YOU (EMPLOYEE) COMPLETE — ALL FIELDS MUST BE COMPLETED!

Employee Name	Member ID #/Social Security #	**Date of Birth** (mm/dd/yyyy)	Sex
		/ /	o Male o Female

Street Address	City	State	Zip

Email	Phone	Language Preference for Healthcare Communications
	( ) -	o English o Spanish o Other:

Date symptoms first appeared	Is disability due to an accident?	If yes, what happened?	Is disability due to work-related illness or injury?	Have you filed (or do you plan to file) a workers' comp claim?
/ /	o Yes o No		o Yes o No	o Yes o No
Return to work date / /	**Date** / /		If "yes," attach a copy of award letter OR supply type of benefits, amount, frequency, phone, and identification number of source (attach a separate paper if needed)	
o Actual o Possible	Time			
	Place			

By signing below, I agree that:
- These statements are true and complete.
- I give my permission to my employer and providers to share any and all information needed by UNITE HERE HEALTH to assess, manage, and/or administer my claims for benefits.

And I understand that:
- My information will be shared when required by law.
- I can revoke this permission at any time.
- I can receive a copy of this form when requested. A photocopy is as effective and valid as the original.

Employee Signature — REQUIRED!	**Date**
	/ /

STEP 2: YOUR EMPLOYER COMPLETES — ALL FIELDS MUST BE COMPLETED!

Employer Name	Employee Job Title	**Actual Last Day Worked**
		/ /

Street Address	City	State	Zip

Is disability due to employment?	**If yes, has a workers' comp claim been filed?**	Can employee's job be modified to return to work?	**Date employee returned to work**
o Yes o No	o Yes (submit copy with form) o No	o Yes o No o Maybe (with restrictions)	/ /

Please include job description and list of restrictions that can't be modified

I certify that I have reviewed the above information and the employee named has been an active employee for whom contributions have been paid.

Authorized Employer Signature — REQUIRED!	**Date**	Email
	/ /	

Printed Name	Title	Phone	Fax
		( ) -	( ) -

STEP 3: YOUR DOCTOR COMPLETES — ALL FIELDS MUST BE COMPLETED!

o New disability o Extension request	Diagnosis(es)	ICD-10 diagnosis codes	**Date of first visit for condition**
			/ /

Is patient's disability due to:	Employment?	Pregnancy?	**Dates patient was totally disabled** (couldn't work) — **REQUIRED!**	**Dates patient was hospitalized** (if applicable)	**Dates of treatment for this condition**
	o Yes o No	o Yes o No	**From** / / **to** / /	**From** / / **to** / /	/ /
					/ /

If due to pregnancy, provide **delivery date**	Delivery type	Surgical procedure(s)			
/ /	o Vaginal o C-Section	CPT code(s):		**Date** / /	/ /
o Actual o Estimated		CPT code(s):		**Date** / /	/ /
		CPT code(s):		**Date** / /	/ /

Is the patient still under your care for this condition?	If "yes," are there any activity restrictions?	*Please specify restrictions*	**Date of patient's next appointment**	**Anticipated date to return to work**
o Yes o No	o Yes o No		/ /	/ /

Physician Signature — REQUIRED!	**Date**	Email
	/ /	

Printed Name	Specialty	**Phone — REQUIRED!**	**Fax — REQUIRED!**
		( ) -	( ) -

Street Address	City	State	Zip	Tax ID #