HOSPITALITY PLAN
UNITE HERE HEALTH

Short-Term Disability Form

Updated: 2/15/24

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: 5655 Badura Ave, Ste 180
Las Vegas, NV 89118

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? o Yes o No	If yes, what happened?	Is disability due to work-related illness or injury? o Yes o No	Have you filed (or do you plan to file) a workers' comp claim? o Yes o No
Return to work date / / o Actual o Possible	**Date** / / Time Place		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)	

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

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

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

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

Physician Signature — REQUIRED!	**Date** / /	Email
Printed Name	Specialty	**Phone — REQUIRED!** ( ) - / **Fax — REQUIRED!** ( ) -
Street Address	City / State	Zip / Tax ID #