HBPA
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New Orleans, LA 70119
Fax(504)910-8290
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LAHBPA Medical Form

GROOMS, HOT WALKERS, EXERCISERS, ETC.
TO BE COMPLETED BY THE INSURED
EACH JANUARY AND JULY

Date: _____

1. Name _____ Soc. Sec. # _____
   (Please Print) First Middle Initial Last
2. Present Address _____ Telephone # _____
   Street City State Zip
3. Permanent Address _____ Birthdate_____ Sex___M___F
   Street City State Zip
4. How long licensed in LA? _____ LSRC#_____ Date Obtained _____
5. Name of Employer_____ Length of time employed: Years _____ Months_____
   Address _____ Telephone # _____
   Street City State Zip
6. Employed Fulltime Yes _____ No _____ Employed Part time Yes____ No _____ Occupation_____
7. Are you listed on your employer's work list? Yes _____ No _____
   If yes, give the name of the track _____
8. Date and name of horse last started by present employer
   Date _____ Name of horse _____ Name of track _____
9. Give names of previous employers for the past two years
   Name _____ Length of time employed: Years _____ Months _____
   Name _____ Length of time employed: Years _____ Months _____
10. Tracks presently employed _____
11. Does your employer have Workers' Compensation? Yes _____ No _____
12. Marital Status ____Married ____Single ____Divorced ____Legally Separated ____Widowed
    Name of Spouse_____ Spouse SS# _____ Date of Birth _____
13. Is spouse employed? _____ Name of spouse's employer _____
    Address _____
    Street City State Zip
    Name and Address of spouse's group health plan _____
    Address _____
    Street City State Zip
14. List Names and Addresses of *ALL* Medical insurances:
    Name _____ Address _____
    Individual/Group #_____ Deductible $ _____ Coverage for: ____Self ____Spouse ____Dep. Children
    Name _____ Address _____
    Individual/Group #_____ Deductible $ _____ Coverage for: ____Self ____Spouse ____Dep. Children
15. Dental Coverage ____Yes ____No Prescription Coverage ____Yes ____No Optical Coverage ____Yes ____No
16. Does automobile insurance provide for medical/hospital expenses for injuries sustained in auto accident? ____Yes ____No

OUR RIGHTS TO RECOVER FROM OTHERS: If HBPA makes any payment, HBPA is entitled to recover what is paid from other parties. Any person to or for whom the HBPA makes payment must transfer to it his or her rights of recovery against any other party. This person must do everything necessary to secure these rights and must do nothing that would jeopardize them. Such person agrees to assign and subrogate HBPA for any monies he or she may received from other parties to the extent of the benefit payment made by HBPA

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the HBPA to release or obtain any information which may be necessary to determine benefits payable under the benefit Plan. In the event of any of the information furnished is false or incorrect, I understand that my application for medical benefits will be denied. Also, at the request of the HBPA's authorized representative I must furnish proof of my employment.

IMPORTANT NOTICE: Under the Louisiana HBPA rules, the issuance and submission of a claim form does not constitute acceptance of an individual's eligibility under the Plan, or guarantee of benefit payment. The determination of eligibility and amount of any benefits payable are subject to the terms of the Plan at the time a claim occurs. Payment of any benefits to anyone eligible under the provisions of this medical benefit Plan shall be discretionary with the Benevolence Committee and/or the Board of Directors of HBPA.

It is understood and agreed by participants that any decisions of the Benevolence Committee and/or the HBPA's Board of Directors as to eligibility for and/or enlightenment to medical benefits under the Plan shall be final.

Date _____ Signature of Applicant _____

NOTE: THIS APPLICATION MUST BE SIGNED BY YOUR EMPLOYER
EMPLOYER: PLEASE SIGN THIS APPLICATION
I understand at the request of the HBPA I will furnish the necessary payroll records to verify his/her employment

Date _____ Barn # _____ Signature of Employer _____

ALL QUESTIONS MUST BE COMPLETED