HBPA
1535 Gentilly Blvd
New Orleans, LA 70119
Fax(504) 910-8290
Email medical@lahbpa.org

LAHBPA Medical Form

TO BE COMPLETED BY
OWNER / TRAINER
EACH JANUARY AND JULY

Date: _____

1. Name _____ Soc. Sec. # _____
   (Please Print) First Middle Initial Last
2. Present _____ Telephone # _____
   Address Street City State Zip
3. Permanent _____ Birthdate _____ Sex___M___F
   Address Street City State Zip
4. Place of Business _____
   Or Employment Name City State Zip
5. Currently Licensed as ____Owner ____Trainer ____Owner/Trainer Date Obtained_____
6. If Owner, Give Name of Trainer _____
7. If Trainer, Give name(s) of one or more Owner(s) for whom you train _____
   _____
8. Are you in a Partnership? If Yes, give name of Partner(s) _____
9. Check all Tracks at which previously raced in the past 6 months. Give date of last start at each Track
   Fair Grounds _____ Date _____ Evangeline Downs _____ Date _____
   Delta Downs _____ Date _____ Harrah's LA Downs _____ Date _____
10. Marital Status ____Married ____Single ____Divorced ____Legally Separated ____Widowed
    Name of Spouse_____ Spouse SS# _____ Date of Birth _____
11. 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
12. Dental Coverage ____Yes ____No Prescription Coverage ____Yes ____No Optical Coverage ____Yes ____No
13. Does automobile insurance provide for medical/hospital expenses for injuries sustained in auto accident? ____Yes ____No
14. Number of Dependent Children? _____
    Name Date of Birth Name of School Attending
    _____
    _____
    _____
15. Name and Address of School Insurance _____

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.

IMPORTANT NOTICE: Under the 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.

I UNDERSTAND THAT FAILURE TO DISCLOSE OTHER MEDICAL INSURANCE WILL DISQUALIFY ME FOR BENEFITS FOR TWO (2) YEARS.

_____ BARN # _____ TRACK _____
SIGNATURE ALL QUESTIONS MUST BE COMPLETED