Please fill out and return to:
H.B.P.A.
1535 Gentilly Blvd
New Orleans, LA 70119

TO BE COMPLETED BY
OWNERS, TRAINERS, 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

   Fairgrounds_____ Date_____ Evangeline Downs_____ Date_____
   Delta Downs_____ Date_____ Harrah's LA Downs_____ Date_____

10. Marital Status _____Married _____Single _____Divorced _____Legally Separated _____Widowed

    Name of Spouce_____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 receive 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, nor a 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 TOW (2) YEARS.

_____BARN # _____ TRACK_____
SIGNATURE

ALL QUESTIONS MUST BE COMPLETED

Revised: 8/94