

Please fill out and return to:
H.B.P.A.
1535 Gentilly Blvd.
New Orleans, LA 70112

GROOMS, HOT WALKERS, EXERCISERS, ETC.
TO BE COMPLETED BY THE INSURED

DATE: _____

1. Name _____ Birthdate _____ Sex M F
(Please Print) First Middle Initial Last
2. Present _____ Telephone # _____
Address Street City State Zip
3. Permanent _____ Telephone # _____
Address Street City State Zip
4. Social Security No. _____ La. State Racing License No. _____ Date Obtained _____
5. How long licensed in La? _____ Occupation _____
6. Name of Employer _____ Length of Time Employed: Years _____ Months _____
Address _____ Telephone _____
Street City State Zip
7. Employed Fulltime Yes No Employed Part Time Yes No
8. Are you listed on your employer's work list: Yes No
If yes, give name of track _____
9. Date and Name of Horse Last Started by Present Employer
Date _____ Name of Horse _____ Name of Track _____
10. Give Names of Previous Employers for the past two years
Name _____ Length of time Employed: Years _____ Months _____
Name _____ Length of time Employed: Years _____ Months _____
11. Track Presently Employed _____
12. Does your employer have Workmen's Compensation? Yes No
13. Marital Status:
Married Single Divorced Legally Separated Widowed Spouse Soc. Sec. No. _____
Name of Spouse _____ Date of Birth _____
14. Is Spouse Employed? _____ Name of Spouse's Employer _____
Address _____
Street City State Zip
Name and Address of Spouse's Group Health Plan
Address _____ Group # _____ Individual # _____
Street City State/Zip
15. Number of Dependent Children? _____
Name _____ Date of Birth _____ Name of School _____

Name and Address of School Insurance _____
16. List Names and Addresses of all other Medical Insurances
Name _____ Address _____ Group# _____ Individual # _____
Name _____ Address _____ Group# _____ Individual # _____
Dental Coverage Yes No Optical Coverage Yes No
17. Medical and Hospital Automobile Insurance as a Result of injuries sustained in an Auto Accident Yes No

Barn No. _____ Track _____

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. Also, at the request of the HBPA's authorized representative I must furnish proof of my employment.

IMPORTANT NOTICE: Under the Louisiana Division 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.

Date _____ Signature of Applicant _____

NOTE: THIS APPLICATION MUST BE SIGNED BY YOUR EMPLOYER

EMPLOYER: PLEASE SIGN THIS APPLICATION

Applicant has been in my employment for : Years _____ Months _____

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 _____

Telephone _____

ALL QUESTIONS MUST BE COMPLETED