2016 APPLICATION
INDIANA HBPA BENEVOLENCE

** For any answer that requires more space than the form allows, write on the back of the form.*
*** Owners and Trainers need only fill out the Application with the initial application each year.*

LICENSEE
FULL NAME ______________________________ SOCIAL SECURITY # ______________________

MAILING ADDRESS ____

CURRENT ADDRESS ____

TELEPHONE ______________________ DATE OF BIRTH ________________ AGE __________

DO YOU FILE TAXES? __________ EMAIL ADDRESS _____________________________________

LIST ALL CURRENT INDIANA RACING LICENSES THAT YOU HAVE BEEN ISSUED

	TYPE	LICENSE NUMBER	DATE ISSUED
1.			
2.			
3.			

STATES IN WHICH YOU ARE LICENSED, OTHER THAN INDIANA ______________________________

ALL EMPLOYERS, ON & OFF THE TRACK, FOR WHICH YOU HAVE WORKED **90 DAYS PRIOR** TO REQUEST

	EMPLOYER	LOCATION OF EMPLOYMENT	DATE STARTED	DATE LEFT
1.				
2.				
3.				
4.				

LIST ALL INCOME WHICH YOU CURRENTLY EARN, **ON & OFF** THE TRACK

	EMPLOYER	OCCUPATION	WEEKLY SALARY	HOURS/HORSES
1.				
2.				
3.				
4.				

CLAIMANT'S NAME ______________________________ RELATIONSHIP TO LICENSEE __________

CLAIMANT'S AGE__________ DATE OF BIRTH ______________________

IS THE CLAIMANT'S ILLNESS OR INJURY IN ANY WAY RELATED TO YOUR EMPLOYMENT? __________

IF YES, EXPLAIN____

HAS THE CLAIMANT RECEIVED ANY ASSISTANCE FROM ANOTHER STATE'S HORSEMEN'S ORGANIZATION DURING THE PAST SIX MONTHS? ___________ IF YES, WHICH STATE(S)?______________________

REASON? ____

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ARE YOU (*CIRCLE ONE*) SINGLE LEGALLY MARRIED DIVORCED SEPARATED

SPOUSE'S NAME ________________________________ EMPLOYER ____

ALL EMPLOYERS, ON & OFF THE TRACK, FOR WHICH YOUR SPOUSE HAS WORKED **90 DAYS** PRIOR TO REQUEST

EMPLOYER	**LOCATION OF EMPLOYMENT**	**DATE STARTED**	**DATE LEFT**
1			
2			
3			

LIST ALL INCOME WHICH YOUR SPOUSE CURRENTLY EARNS, **ON & OFF** THE TRACK

EMPLOYER	**OCCUPATION**	**WEEKLY SALARY**	**HOURS/HORSES**
1			
2			
3			

DO YOU OR YOUR SPOUSE HAVE:

Health Insurance? *Yes* ____ *No* ____ *if yes, please list Insurance Company*__________________________

Dental Insurance? *Yes* ____ *No* ____ *if yes, please list Insurance Company*__________________________

Vision Insurance? *Yes* ____ *No* ____ *if yes, please list Insurance Company*__________________________

Accident Insurance? *Yes* ____ *No* ____ *if yes, please list Insurance Company*__________________________

Medicare, Medicaid or Veteran's Benefits? *Yes* ____ *No* ____ *if yes, which one/s?*__________________________

WHAT WAS ***ADJUSTED GROSS INCOME*** ON YOUR FEDERAL TAX RETURN LAST YEAR?
If Single: ______ under $50,000 If Married: _______under $100,000 (***TOTAL*** *of your income plus your spouse's)*
______ over $50,000 _______over $100,000 (***TOTAL*** *of your income plus your spouse's)*

I hereby request financial assistance from the Indiana HBPA Benefit Trust Fund. My request is based on the fact of financial need. I certify that the statements contained herein are true and correct to the best of my knowledge and belief. ***I understand that any falsified information or abuse of the Indiana HBPA Benefit Trust Fund may lead to permanent loss of benevolence privileges and/or legal action****. I authorize the release, when requested by Indiana HBPA Benefit Trust, of any facts concerning injury, illness and treatment of my dependents and myself. I acknowledge that I have been advised that a full copy of the Indiana HBPA Benevolence Guidelines is available or can be accessed at www.inhbpa.org, and that I have received a copy of my Notice of Privacy Practices.*

SIGNATURE OF LICENSEE ____DATE ________________
(or parent/guardian of licensee if under age 18)

SIGNATURE OF EMPLOYER ____DATE ________________
(not necessary if you are a trainer or owner)

APPLICATION RECEIVED BY ____DATE ________________

APPLICATION APPROVED BY ____DATE ________________

INDIANA H.B.P.A.

2016 Request For Benevolence Benefits

NOTE: THIS FORM MUST BE SUBMITTED WITH EVERY CLAIM FOR BENEFITS, NO EXCEPTIONS.

NAME OF LICENSEE ____

LICENSE TYPE ______________ DATE ________________ LICENSE NUMBER ________________________

CLAIMANT'S NAME _______________________ RELATIONSHIP TO LICENSEE ______________________

CLAIMANT'S AGE __________________ DATE OF BIRTH ________________________________

MAILING ADDRESS ___*(street)*____

___(city)_________________________ (state) __________ (zip) ___________

PHONE# ___________________________________ EMAIL ADDRESS: ______________________________

IS YOUR ILLNESS OR INJURY IN ANY WAY RELATED TO YOUR EMPLOYMENT? __________________
IF YES, EXPLAIN ____

NOTE: PLEASE LIST ALL PAYMENT REQUESTS. ATTACH ORIGINAL INVOICE SHOWING DATE OF SERVICE, PATIENT NAME, AND ANY EVIDENCE OF PAYMENT. ALL PHARMACY REQUESTS MUST INCLUDE RECEIPT PLUS PRESCRIPTION TAG SHOWING PATIENT NAME AND AMOUNT OF PRESCRIPTION.

Date of Service	***Name of Provider (hospital, lab, doctor, dentist, pharmacy, etc)***	***Amount***	***Reimburse Provider or Applicant??***
	Total of this request:		

SIGNATURE OF LICENSEE ____ DATE ________________
(or parent/guardian of licensee if under age 18)

SIGNATURE OF EMPLOYER ____ DATE ________________
(not necessary if you are a trainer or owner)

FOR USE BY HBPA ONLY – DO NOT WRITE BELOW THIS LINE:

Claim Approved by: ____________________________ *Date* ___________________ *CLAIM PAID DATE* _________

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