

# 2014 APPLICATION

## INDIANA HBPA BENEVOLENCE

*\* For any answer that requires more space than the form allows, write on the back of the form.*

### 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? \_\_\_\_\_



INDIANA H.B.P.A.

2014 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.

Table with 4 columns: Date of Service, Name of Provider (hospital, lab, doctor, dentist, pharmacy, etc), Amount, Reimburse Provider or Applicant??

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 \_\_\_\_\_

2138746.1

CLAIM PAID DATE \_\_\_\_\_