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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