

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 Spouse _____ 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.

SIGNATURE BARN # _____ TRACK _____

ALL QUESTIONS MUST BE COMPLETED

Revised: 8/94