Thoroughbred Racing Association of Oklahoma
One Remington Place • Oklahoma City, Oklahoma 73111
Telephone: 405.427.8753 • Fax 405.427.7099 • hlawson@traoracing.com

2017 BENEFIT REQUEST FORM

REMEMBER:

THIS IS NOT AN INSURANCE PROGRAM. IT'S AN OWNER FUNDED ASSISTANCE PROGRAM. THIS PROGRAM IS NOT INTENDED TO SUBSTITUTE FOR PRIVATE INSURANCE. ALL TRAO MEMBERS ARE ENCOURAGED TO CARRY INSURANCE FROM A PROVIDER IN CASE OF CATASTROPHIC ILLNESS.

PLEASE READ THE FOLLOWING CAREFULLY

1.To become eligible for benevolence assistance during the current calendar year, the TRAO member must have a minimum of (10) starts from the previous calendar year or a minimum of (5) starts in the current calendar year.

2. FREE-LANCE EXERCISE PERSONNEL AND PONY PERSONNEL are NOT eligible for benevolence

3. All benevolence requests MUST fill out this form and provide a **CURRENT copy of their OHRC license**

4. Benevolence benefits will be DENIED until these steps have been completed. All TRAO members employees' requesting benevolence must have their employer sign the benevolence request form prior to the issuance of benevolence benefits.

5. Owner, Trainer and Assistance Trainers dependents under the age of 18 are eligible

6. When submitting reimbursement for Medical, Dental, Optical or RX, the **ORIGINAL** receipt and/or billing invoice must accompany the request. This includes what the prescription is written for. The TRAO will supply copies to the benevolence requestor of the original receipt upon request

7. ALL benevolence requests must be made within **sixty (60)** days of the procedure

This Form Must Be Completed To Receive Consideration For Payment:

Name:_____ SS#:_____

Address:_____

Telephone:_____DOB:_____Ins. Yes____ No_____

Employer:_____ Hire Date:_____

# of Starts_____ Type of License_____

REQUEST FOR (check one) **MEDICAL_____ DENTAL_____ OPTICAL_____ OTHER_____**

Brief Description of needs: _____

Employer Signature:_____ Date:_____

If racing under a partnership state the name:_____

Has Claimant or Employer started horses:

2017: TRACK:_____ DATE:_____HORSE:_____

2016: TRACK:_____ DATE:_____HORSE:_____

Attach all bills or paid receipts and return with application within 60 days from the date of service to:

TRAO
1 Remington Place
Oklahoma City, OK 73111
ATTN: Heather

To assist the TRAO in determining my eligibility for the benevolence program,
I authorize the release of any medical, dental, insurance or other HBPA affiliates records for myself to:

THOROUGHBRED RACING ASSOCIATION
dba
OKLAHOMA HORSEMEN'S BENEVOLENT & PROTECTIVE ASSOCIATION

Signature_____***Date***_____

Oklahoma Horsemen's Benevolent & Protective Association

Authorization for Use and Disclosure of Protected Health Information

Please fill out highlighted areas only

Name_____ Date_____

Birth Date_____ SSN_____

Account/Health Record Number_____

I authorize **Oklahoma Horsemen's Benevolent & Protective Association, dba TRAO 1 Remington Pl, Oklahoma City, OK 73111** to receive my free copy of the information from:

The following individually identifiable health information may be used and/or disclosed:

Check all that apply:

_X_ Discharge Summary	_X_ Reports of Lab Test
_X_ History and Physical Records	_X_ Reports of X-Rays
_X_ Face Sheet	_X_ Emergency Room Records
_X_ Consultation Reports	_X_ Operative Reports
_X_ Pathology Reports	_X_ Payment/Billing Records
_X_ Psychotherapy Notes	_X_ Other_____

Dates of treatment to be released_____

The above mentioned health record is being requested to process my request for assistance with incurred charges.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, psychiatric/mental health treatment and/or HIV related conditions.

I understand that I have the right to revoke this Authorization, if the revocation is in writing and delivered to the **Oklahoma Horsemen's Benevolent & Protective Association.** Any revocation will have no effect on any action taken by the **Oklahoma Horsemen's Benevolent & Protective Association** in reliance upon this Authorization and prior to receiving any revocation.

By signing this Authorization, I acknowledge that I have read and understand this Authorization; I authorize the use and disclosure of my health information and in accordance with the terms of this Authorization. Further, I give authorization for any health information records to be sent to the **Oklahoma Horsemen's Benevolent & Protective Association** via fax.

X

Signature of Individual or Personal Representative **Date**

This authorization expires on December 31, 2017

Phone: (405) 427-8753 Fax: (405) 427-7099