

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?

You MUST have had 10 starts in 2020 OR 5 starts in 2021 to qualify for Benevolence

2020: TRACK: _____ HORSE: _____

2021: TRACK: _____ 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 _____

**By signing, you acknowledge that you have read and understand the
TRAO's Benevolence guidelines and rules.**



Thoroughbred Racing Association of Oklahoma

One Remington Place • Oklahoma City, Oklahoma 73111

Telephone: 405.427.8753 • Fax 405.427.7099 • hlawson@traoracing.com

2021 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

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:

<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Reports of Lab Test
<input checked="" type="checkbox"/> History and Physical Records	<input checked="" type="checkbox"/> Reports of X-Rays
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Emergency Room Records
<input checked="" type="checkbox"/> Consultation Reports	<input checked="" type="checkbox"/> Operative Reports
<input checked="" type="checkbox"/> Pathology Reports	<input checked="" type="checkbox"/> Payment/Billing Records
<input checked="" type="checkbox"/> Psychotherapy Notes	<input checked="" type="checkbox"/> 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.

Signature of Individual or Personal Representative **Date**

This authorization expires on December 31, 2021

Phone: (405) 427-8753

Fax: (405) 427-7099