

# Benevolence Assistance Request

2019 Race Meets

Remington Park  Fair Meadows  Will Rogers

(Please Check One)

***This Form Must Be Completed To Receive Consideration For Payment:***

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Employer \_\_\_\_\_ Type of License: \_\_\_\_\_

Relationship of claimant to eligible applicant:: \_\_\_\_\_

# of Starts \_\_\_\_\_

### **Has Applicant or Employer started horses:**

2019: TRACK: \_\_\_\_\_ BREED: \_\_\_\_\_ DATE: \_\_\_\_\_ HORSE: \_\_\_\_\_

2018: TRACK: \_\_\_\_\_ BREED: \_\_\_\_\_ DATE: \_\_\_\_\_ HORSE: \_\_\_\_\_

**THIS IS A PRIVATELY FUNDED BENEVOLENCE PROGRAM ADMINISTERED BY OQHRA THROUGH A BENEVOLENCE COMMITTEE. IT IS NOT INSURANCE.**

Employer or Applicant Signature: \_\_\_\_\_

\*\*\*\*\*

Request for (check one)  Medical  Dental  Optical  Other

**Describe Need:**

\_\_\_\_\_

**Attach copies of all bills or paid receipts and return with application within 90 days from date of service.**

**Do you have health insurance?**  Yes  No

Will it cover any of the expense? If Yes, what portion will it pay?

\*\*\*\*\*

### **FOR OFFICE USE ONLY:**

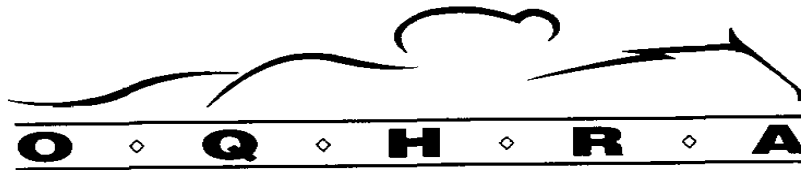
Verification of Eligibility:  yes  no Verify Employer:  yes  no

Refer to approved provider:  medical  dental  eye care

Pay claimant for receipts submitted with request

Pay Provider

\$ \_\_\_\_\_ Amount Approved from Fund Date Paid \_\_\_\_\_



# Benevolence Health Program for 2019 Race Meet at

*Remington Park, Will Rogers Downs and Fair Meadows*

**ELIGIBILITY REQUIREMENTS:** Must be licensed by OHRC for participation in the actual racing activities on the backside of an OK racetrack (example: Trainer, owner-trainer, owner, rider, exercise rider, groom, jockey agent, and backside track employees such as paddock judge, entry clerks, gate crew, etc. from the racetrack. Only dependents in the immediate family of an eligible beneficiary are eligible for consideration of benefits. All eligible beneficiaries **MUST** have participated in a live race meet during the current or immediate past year unless approved for an exception. Exceptions may be considered and approved by the OQHRA board of directors. Horsemen opting out of OQHRA participation are not eligible for benefits during that meet. Horsemen submitting requests for reimbursement must submit original paid receipts for services.

*NOTE: Preference will be given for those in need who cannot pay for them or would otherwise go without a necessary service. This service is not health insurance!! This program is a tool to help the horsemen's representative and the chaplain assist those who are in need. Please help us avoid abuse of this system so that funds will be available for those who need the help! \*Some services are not automatically approved on an annual basis and may be subject to approval of treatment plan or doctors recommendation*

## **GUIDELINES:**

1. Requests for reimbursement with PAID RECEIPTS are requested within 90 days of service.
2. Except in emergency situations, the total payment on all Applications for Aid shall not exceed the applicant's annual individual limits set forth below.
2. The OQHRA may increase these limits in emergency situations.
3. These limits are subject to review by the Horsemen's Benevolence Committee or OQHRA board.
4. Applications for Aid not fully funded during a calendar year may be resubmitted between November 1<sup>st</sup> and December 15<sup>th</sup>, of the current year, for reconsideration based on funds available.

## **ANNUAL LIMIT: (applies to multiple claims in a calendar year)**

Individual Maximum - \$3,500.00 includes eyeglasses and dental

Family Maximum - \$4,000.00

Death Benefit - up to \$2000 .00 (unless approved for exception must be paid to service provider)

## **APPLICATION LIMIT:**

1. Each Application for Aid for \$ 1500.00 or less: FULL AMOUNT
2. Each Application for Aid for more than \$1 500.00: FIRST \$1500.00 plus 50% of Remainder (rounded to nearest dollar) up to the maximum annual limit.
3. Each Application for Aid for Eye Glasses: \$350 \*
4. Each Application for Dental: NOT TO EXCEED \$1,000.00  
Unless specific treatment plan is approved by OQHRA. Annual Cleaning is not covered in dental benefit.

## **COMPLETED APPLICATIONS:**

OQHRA Benevolence Administrator

Phone 405-216-0440 or Fax 405-216-0770

PO Box 2907 Edmond, OK 73083 or oqhra3@aol.com

