Mountaineer Park Benevolent Trust Application

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Social Security #:_____

Date of Birth:_____WV Racing Commission Permit #:_____

Please indicate how you are licensed by the State of West Virginia

___Trainer
___Assistant Trainer
___Groom
___Owner/_____(Indicate license for which you are applying for benefits)
___You are not licensed but applying as a:
___Non-paid spouse
___Dependent of _____(eligible permitholder)

Do you receive benefits from any other racetrack medical trust during our racing meet?_____

Do you currently have medical insurance? Yes / No. If yes, please list the name of the insurance company:_____

I _____ am licensed by the State of West
(name)
Virginia and hold a permit as a _____. I am
(position)
I have held this position since _____.
(hire date)

By signing this Affidavit of Eligibility I acknowledge:

- I have read this form and all of the eligibility requirements, and by my signature acknowledge that all statements are true and correct.
- I understand if any of these statements are untrue and information to determine eligibility has been falsified I will forfeit all entitlements to current and future benefits provided by the Mountaineer Park HBPA Medical Trust and would be required to repay benefits paid based on false claims.
- The Trustees may require you to provide additional documentation to verify your eligibility (1099, W2, Tax Documentation)
- All bills being submitted for reimbursement must be turned in within 60 days of service date.
- Benefits are only available during the live race meet.

Signed_____Date_____Print Name:_____

Witness or Notary_____

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, the Mountaineer HBPA Benevolent Trust originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, billing and payment records, and
Any plans for future care or treatment, I understand this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health care professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information for payment of my bill
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I herby consent to the release by the Trust of my healthcare information for the purpose of Carrying out treatment, payment or healthcare operations relating to my healthcare.

I understand that I have the right to object to the use of my healthcare information. I understand that I have the right to request restrictions as to how my health information may be used to disclose to carry out treatment, payment or healthcare operations and that the Trust is not required to agree to the restrictions requested. I understand that my objection to the use of my healthcare information as described to me on this form may result in non-payment of the charges, which will be presented to the Trust. I understand that I may revoke this consent in writing, except to the extent that the Trust has already taken action in reliance thereon.

I acknowledge that I have read the Mountaineer HBPA Benevolent Trust notice of Privacy Practices.

_____ OR _____

Signature of Patient

Signature of Authorized Representative
(Parents sign here for children)

_____ _____

Date

Relationship to Patient