NEW MEXICO HORSEMEN'S ASSOCIATION MEDICAL BENEFIT CLAIM FORM

All parts of this form must be completed and turned in with an itemized statement

DATE: _____

NAME _____**PHONE**_____

ADDRESS _____

NEW MEXICO STATE RACING COMMISSION: LICENSE # _____ **DATE EXPIRED** _____

(circle one) **OWNER TRAINER ASST TRAINER GROOM PONY PERSON EXERCISE PERSON**

NAME OF EMPLOYER: _____ **BARN #**_____

Please fill out section A or B or C

A) ILLNESS Symptoms: _____
_____

B) ACCIDENT Where did accident occur? **BARN AREA** **RACETRACK**
What happened? _____
_____

C) PRESCRIPTIONS Please get a prescription history printout from your Pharmacist.

Do you have insurance or Medicare? (circle one) **YES** **NO**
(If you answered yes to the above questions you must file with that company first, then bring your explanation of benefits EOB to the NMHA office.)

NAME OF HORSES: _____

DATE LAST RAN: _____**Track:** _____

STABLE NAME/PARTNERSHIP: _____

ILLNESS ELIGIBILITY AMOUNTS PER YEAR

Trainer & Immediate Family	$2500	per family
Owner & Immediate Family	$2500	per family
Asst. Trainer (no family)	0	
Groom	0	
Exercise Rider	0	
Pony Person	0	

ACCIDENT ELIGIBILITY AMOUNTS (HORSE RELATED) PAY PER ACCIDENT

Must be horse related and occur on a NMRC licensed racetrack grounds

Trainer	$3000
Owner	$3000
Asst. Trainer	$3000
Groom	$3000
Pony Person	$3000
Exercise Person (in barn area **ONLY**)	$3000

_____ _____
Signature of Applicant Trainer Signature (If Applicable)

Amount change approved at NMHA state board meeting March 11, 2015