QHRAI Benevolence Health Program - Claim Form

THIS IS A PRIVATELY FUNDED BENEVOLENCE PROGRAM ADMINISTERED BY THE QUARTER HORSE RACING ASSOCIATION OF INDIANA. THIS IS NOT INSURANCE.

THIS FORM MUST BE COMPLETED TO RECEIVE CONSIDERATION FOR PAYMENT

(Please read the benevolence eligibility requirements on the web at INQRacing.com)

NAME_____DATE OF BIRTH_____

ADDRESS_____

_____

PHONE NUMBER_____E-MAIL ADDRESS_____

ARE YOU A CURRENT QHRAI MEMBER? _____YES _____NO

TYPE OF IHRC LICENSE_____LICENSE NUMBER_____

A COPY OF YOUR IHRC LICENSE MUST BE ATTACHED WITH THE FIRST CLAIM SUBMITTED EACH YEAR.

How many quarter racing horses do you own and have in current race training? _____

Have you conducted at least 50% of your quarter horse racing business in Indiana during current or past year? _____

CLAIM IS FOR (CHECK ONE): _____SELF _____SPOUSE _____CHILD

State a brief description of your involvement in Quarter Horse Racing in Indiana for the current and past year:

_____

_____

REQUEST FOR (CHECK ONE): _____Medical _____Dental _____Optical _____Prescription

Describe Need _____

_____

Do you have health insurance? _____Yes ____No If yes, what percentage of this expense will it cover? _____

Dollar amount of reimbursement you are requesting: $_____

SIGNATURE OF CLAIMANT _____DATE_____

Claims that have been paid within the past 90 days will be considered and a copy of each paid bill identifying the name of the person the claim is for must be attached. (A cash register or credit card receipt is not acceptable).

Claims may be submitted at a monthly scheduled QHRAI Board of Directors Meeting or returned to:

QHRAI Benevolence Administrator
P O Box 399
Shelbyville, IN 46176