



# Benevolence Assistance Request

## 2024 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:**

2024: TRACK: \_\_\_\_\_ BREED: \_\_\_\_\_ DATE: \_\_\_\_\_ HORSE: \_\_\_\_\_  
2023: 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 2024 Race Meet at**

## **Remington Park, Fair Meadows and Will Rogers Downs**

**ELIGIBILITY REQUIREMENTS:** Must be licensed by the 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 authorized 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 (or worked for a trainer) with a **minimum of five** Quarter Horse, Paint or Appaloosa starts in the last 12 months or participated in actual live racing activities for a minimum of 30 days 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 that 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. With exception for emergency scenarios, the total payment on all applications for aid shall not exceed the applicant's annual individual limits set forth below.
3. The OQHRA may choose to increase these limits in case of emergency.
4. These respective limits are subject to review by the Horsemen's Benevolence Committee or OQHRA Board.
5. 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. (Qualifying spouses will each receive the individual maximum.)

**Family Maximum - \$4,000.00** (Applicant and dependents and/or unqualifying spouses.)

**Death Benefit - Up to \$4,000.00** (Unless approved for exception must be paid to service provider.)

### **APPLICATION LIMIT:**

1. Each Application for Aid \$1,500.00 or less: FULL AMOUNT
2. Each Application for Aid more than \$1,500.00: FIRST \$1,500.00 plus 50% of Remainder (rounded to nearest dollar) to the maximum annual limit.
3. Each Application for Aid for Eye Glasses: \$350.00
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:**

**Send to: Benevolence Administrator: OQHRA**

**PO Box 2907 Edmond, OK 73083**

**E-Mail: [Monica.S@oqhra.com](mailto:Monica.S@oqhra.com) | (Or give to any OQHRA Director or Staff Person)**