

PLEASE FILL OUT AND RETURN WITH A COPY OF YOUR LICENSE

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: _____

AMOUNTS ARE REDUCED BY 50% FOR 2021

ILLNESS ELIGIBILITY AMOUNTS PER YEAR

Trainer & Immediate Family	\$2500	\$1250	per family
Owner & Immediate Family	\$2500	\$1250	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	\$1500
Owner	\$3000	
Asst. Trainer	\$3000	
Groom	\$3000	
Pony Person	\$3000	
Exercise Person (in barn area ONLY)	\$3000	

Signature of Applicant

Trainer Signature (If Applicable)