New England HBPA Eyeglass Coverage

Please Print: Date: / /

1. Name of Trainer/Spouse: _____
    a. Social Security # _____
    b. Date of Birth _____/_____/_____

    Phone # you can be reached at _____

    Email you can be reached at _____
2. Address: _____

    _____

3. How many years have you raced in Massachusetts? _____
4. How many horses do you train today? _____
    a. List the horse(s) and when they last raced (use other side if needed)
        i. **Horse** **Last Raced**
5. How many horses have you trained in the past 12 months? _____
6. Do you earn a living as a trainer? _____
7. Do you have medical coverage? _____

8. Are you racing at another track and can or do receive benefits from another NEHBPA?
    a. If so list details
9. Please send a copy of your eyeglass/contact bill We reimburse you ONLY up to $200

Print Name: _____

Sign Name: _____

Send To; NEHBPA PO BOX 550247 North Waltham MA 02455

Review and approval by committee:

Rev01262023