Standardbred Breeders & Owners Association of New Jersey, Inc.

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HEALTH BENEFITS APPLICATION FORM

PRIMARY MEMBER INFORMATION

PLEASE PRINT:

Member's Name: _____
(Last) (M.I.) (First)

Date of Birth: _____ **Sex:** ☐M ☐F **Social Security #:** _____
(MM/DD/YYYY)

Mailing Address: _____
(*If P.O. Box, Street address is needed*)

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you own any horses? ☐No ☐Yes **If yes, how many?** _____ **USTA #:** _____

Employer/Stable Name: _____ **Date of hire:** _____
(MM/DD/YYYY)

SBOA/NJ Health Benefits Eligibility Provisions

The following definitions are only summaries of the requirements used to determine which Group you belong to. More detailed information on each Group is included in the plan document. The Insurance Committee reserves the right to re-categorize any participant they believe does not fit the provisions of the Group they are in.

Group I

Grooms:

- Be licensed by the State of New Jersey
- Derive full income from working as a full-time groom in New Jersey
- Appear on a work roster for a New Jersey trainer; trainer must also provide proof of workers' compensation insurance, and provide payroll checks with deductions for State Federal taxes.
- Own no more than one horse
- Be approved by the Insurance Committee

Group II

Second Trainer:

- Be licensed by the State of New Jersey
- Derive full income from working full time in New Jersey; assists trainer with training duties but does not earn points or pension
- Appear on a work roster for a New Jersey trainer; trainer must also provide proof of workers' compensation insurance, and provide payroll checks with deductions for State and federal taxes.
- Own no more than one horse (with ownership of more than one horse, second trainer must pay the trainer rate, but will not be required to earn points or starts)
- Be approved by the Insurance Committee

Group III

Driver:

- Must have at least 75 starts in New Jersey per calendar year with at least 33 1/3% of total annual starts being in NJ
- Derive the major source of income from driving horses
- Or if over 75 starts in New Jersey, but less than 33% in NJ, as long as they do not qualify for insurance in any other racing jurisdiction.
- Be approved by the Insurance Committee

Trainer:

- Must have at least 24 starts in New Jersey per calendar year, with at least 33 1/3% of total annual starts being in NJ
- Derive the major source of income from training horses
- Or if over 75 starts in New Jersey, but less than 33% in NJ, as long as they do not qualify for insurance in any other racing jurisdiction.
- Be approved by the Insurance Committee

Breeding Farms or Training Center

- Must consist of 25+ acres
- Must board 12 mares and offspring, OR sell 4 offspring per year, OR have proof of commercial offering of 20 turnouts, and provide proof of worker's compensation insurance
- Must maintain racetrack
- Principal Income derive from renting stall space
- Be approved by the Insurance Committee

Senior 65 years and over Group

Retirees:

- Participants age 65 or above (you must sign up for Medicare Part A & Part B when turning 65)
- Must be covered under the SBOA/NJ Health Benefits Plan the day immediately preceding their 65th birthday
- Must have qualifying participation in the industry for at least 25 consecutive years if you are retired
- Be approved by the Insurance Committee

The SBOA health insurance plan is a "health and welfare trust" that is self-insured by the SBOA of New Jersey for the benefit of full time horsemen and women racing in New Jersey. This is not an ERSA employer group plan.

COVERAGE ELECTIONS & MONTHLY PREMIUMS

Group I: Groom

	Single	Two-Person	Family
70%/30% Co-insurance (Dental Included)	☐ $ 50	☐ $ 90	☐ $ 115

Group II: Second Trainer

	Single	Two-Person	Family
70%/30% Co-insurance (Dental Included)	☐ $ 150	☐ $ 280	☐ $ 340

Group III: Driver / Trainer / Farm

	Single	Two-Person	Family
Option A: 70%/30% Co-insurance (Dental Included)	☐ $ 200	☐ $ 370	☐ $ 400
Option B: 80%/20% Co-insurance (Dental Included)	☐ $ 250	☐ $ 463	☐ $ 568
Option C: 90%/10% Co-insurance (Dental Included)	☐ $ 330	☐ $ 568	☐ $ 750

Group V: Medicare

	Single	Two-Person	Family
Senior Medical (Dental & Prescription Extra)	☐ $ 100	☐ $ 200	N/A
Dental & Prescription Coverage	☐ $ 60	☐ $ 120	N/A

OTHER INSURANCE INFORMATION

Are you or any of your dependents covered by any other insurance? ☐**No** ☐**Yes**

If yes, please complete the following information:

Name of Policyholder: _____ **Social Security #:** _____

Name of Other Insurance Company: _____ **Group #:** _____

Insurance Company Address: _____

City: _____ **State:** _____ **Zip:** _____

DEPENDENT INFORMATION

Last name required if different from enrollee's. List only those dependents to be covered:

1.) Spouse's Name: _____

Sex: ☐M ☐F **Date of Birth:** _____ (MM/DD/YYYY) **Social Security #:** _____

Spouse's Employer: _____

Does spouse's employer offer health benefits? ☐No ☐Yes

2.) Dependent's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY)

Relationship: ☐Natural Child ☐Step Child ☐Other _____ **Check if Handicapped** ☐

Sex: ☐M ☐F **Full Time Student?** ☐No ☐Yes **Social Security #:** _____

3.) Dependent's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY)

Relationship: ☐Natural Child ☐Step Child ☐Other _____ **Check if Handicapped** ☐

Sex: ☐M ☐F **Full Time Student?** ☐No ☐Yes **Social Security #:** _____

4.) Dependent's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY)

Relationship: ☐Natural Child ☐Step Child ☐Other _____ **Check if Handicapped** ☐

Sex: ☐M ☐F **Full Time Student?** ☐No ☐Yes **Social Security #:** _____

5.) Dependent's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY)

Relationship: ☐Natural Child ☐Step Child ☐Other _____ **Check if Handicapped** ☐

Sex: ☐M ☐F **Full Time Student?** ☐No ☐Yes **Social Security #:** _____

The information I have supplied on this application is true to the best of my knowledge.

I have read and understand the information provided in the Health Benefits Summary, and I realize that any falsified information which I furnish on this application, on work rosters, or any claims will be considered fraud. Fraudulent behavior will result in the immediate and permanent termination of benefits. I also understand that all claims paid out based on false information will have to be paid back in full, and I will be liable for the full pro-rated cost of my benefits under the health benefit program.

_____ _____

Signature Date

SBOA Use Only

Application Received:		Effective Date Enrollee:	
Application Reviewed:	Approved / Denied	Processed Date:	Initials: