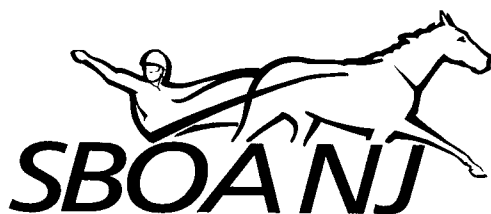


Standardbred Breeders & Owners Association of New Jersey, Inc.

◆64 Business Route 33◆Manalapan, NJ 07726◆
◆T: 732-462-2357◆F: 732-409-0741◆sboanj@optonline.net◆

HEALTH BENEFITS INFORMATION FORM



PRIMARY MEMBER INFORMATION

PLEASE PRINT:

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

Date of Birth: _____ Sex: M F Social Security #: _____
(MMDD/YYYY)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

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: _____
(MMDD/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 New Jersey Racing Commission
- 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
- Own no more than one horse
- Be approved by the Insurance Committee

Group II

Second Trainer:

- Be licensed by the New Jersey Racing Commission
- 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
- 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 100 starts in New Jersey per calendar year with at least 51% of total annual starts being in NJ
- Be approved by the Insurance Committee

Trainer:

- Must have at least 36 starts in New Jersey per calendar year, with at least 51% of total annual starts being in NJ
- **OR** must train 5 or more yearlings in NJ and races less than 36 starts
- Derive the major source of income from training horses
- Be approved by the Insurance Committee

Breeding Farms:

- 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 must provide proof of worker comp. insurance
- Be approved by the Insurance Committee

Group IV

Training Centers:

- Principal income is derived from renting stall space
- Must maintain a racetrack
- Must provide proof of worker comp. insurance
- Be approved by the Insurance Committee

Uncategorized Participants:

- Individuals who do not fit into one particular Group, but have a significant investment in the industry other than being only an owner. Must earn their income from the standardbred industry.
- Be approved by the Insurance Committee

Group V

65+:

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

COVERAGE ELECTIONS & MONTHLY PREMIUMS

Group I: Groom

	Single	Two-Person	Family
70%/30% Co-insurance (Dental Included)	<input type="checkbox"/> \$ 100	<input type="checkbox"/> \$ 185	<input type="checkbox"/> \$ 227

Group II: Second Trainer

	Single	Two-Person	Family
70%/30% Co-insurance (Dental Extra)	<input type="checkbox"/> \$ 150	<input type="checkbox"/> \$ 280	<input type="checkbox"/> \$ 340
Dental Coverage	<input type="checkbox"/> \$ 14	<input type="checkbox"/> \$ 28	<input type="checkbox"/> \$ 36

Group III: Driver, Trainer, Breeding Farm

	Single	Two-Person	Family
Option A: 70%/30% (Dental Extra)	<input type="checkbox"/> \$ 200	<input type="checkbox"/> \$ 370	<input type="checkbox"/> \$ 400
Dental Coverage	<input type="checkbox"/> \$ 14	<input type="checkbox"/> \$ 28	<input type="checkbox"/> \$ 36
Option B: 80%/20% (Dental Included)	<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 463	<input type="checkbox"/> \$ 568
Option C: 90%/10% (Dental Included)	<input type="checkbox"/> \$ 330	<input type="checkbox"/> \$ 568	<input type="checkbox"/> \$ 750

Group IV: Other

	Single	Two-Person	Family
Option A: 70%/30% (Dental Extra)	<input type="checkbox"/> \$ 250	<input type="checkbox"/> \$ 463	<input type="checkbox"/> \$ 568
Dental Coverage	<input type="checkbox"/> \$ 14	<input type="checkbox"/> \$ 28	<input type="checkbox"/> \$ 36
Option B: 80%/20% (Dental Included)	<input type="checkbox"/> \$ 285	<input type="checkbox"/> \$ 527	<input type="checkbox"/> \$ 647
Option C: 90%/10% (Dental Included)	<input type="checkbox"/> \$ 350	<input type="checkbox"/> \$ 647	<input type="checkbox"/> \$ 794

Group V: Medicare

	Single	Two-Person	Family
Senior Medical	<input type="checkbox"/> \$ 100	<input type="checkbox"/> \$ 200	N/A

Optional Coverage

PHCS (National Network of Providers)	<input type="checkbox"/> \$ 10
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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: _____ Social Security #: _____
(MMDD/YYYY)

Spouse's Employer: _____

Does spouse's employer offer health benefits? No Yes

2.) Dependent's Name: _____ Date of Birth: _____
(MMDD/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: _____
(MMDD/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: _____
(MMDD/YYYY)

Relationship: Natural Child Step Child Other Check if Handicapped

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

**If additional space is needed to list dependents, please use separate sheet of paper.

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 _____

<u>SBOA Use Only</u>		
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Change	<input type="checkbox"/> Add
Reason:		
Effective Date:		
Initials:		

<u>The Loomis Company Use Only</u>	
Remarks:	
Effective Date Enrollee:	
Effective Date Dependent:	
Processed Date:	User I.D.:



NORTH AMERICAN BENEFITS COMPANY

Cert. No.

Policy

Last Name

First Name

Initial

Sex

M
F

Date of Birth

Occupation

Name of Employer

Social Security Number

IF PLAN PROVIDES

LIFE OR

ACCIDENTAL

DEATH

INSURANCE,

COMPLETE THIS

PORTION

Beneficiary's last Name

First Name

Initial

Age Relationship to Employee

Primary _____

Contingent _____

Your benefits will be paid to the Primary beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent beneficiary(ies). (Legal appointment of guardian is required if minor is named as beneficiary.)

PLEASE READ, DATE AND SIGN THIS PORTION

I am an active, full-time employee. The complete terms of the group insurance coverage will be set forth in the group insurance policy(ies). If my employer requires contributions for the insurance I have selected, I authorize my employer to deduct such contributions from my wages.

EMPLOYEE SIGNATURE

Date Signed

Signature of Employee

EMPLOYER SIGNATURE

Date Signed

Signature of Employer