

**EQUINE APPLICATION**

Desired Effective Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Is this:  New Business  Renewal  Additional Coverage    Current Policy Number: \_\_\_\_\_

**COVERAGES DESIRED**

Full Mortality     Major Medical \$7,500     Major Medical \$10,000     Major Medical \$15,000     Surgical

Colic Treatment     Loss of Use     Stallion Accident, Sickness & Disease     Specified Perils

**ANIMAL INFORMATION**

1. Name of Animal		Breed	DOB	Sex	Use	Value Desired	Premium
USEF/FEI/Microchip #	Sire	Dam		Purchase Price/Date		Rate	
2. Name of Animal		Breed	DOB	Sex	Use	Value Desired	Premium
USEF/FEI/Microchip #	Sire	Dam		Purchase Price/Date		Rate	
3. Name of Animal		Breed	DOB	Sex	Use	Value Desired	Premium
USEF/FEI/Microchip #	Sire	Dam		Purchase Price/Date		Rate	

**ANIMAL INFORMATION CONTINUED**

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1. Are any of the animals listed herein financed or leased?  Yes  No  
If so, state amount, when and to whom due. (Give Address): \_\_\_\_\_
2. Is there any other insurance on any of the animals listed herein?  Yes  No
3. Chiefly kept on premises known as: \_\_\_\_\_
4. Name and address of trainer: \_\_\_\_\_
5. If mare is in foal, name covering stallion & stud fee paid: \_\_\_\_\_ Due date: \_\_\_\_\_
6. Has any animal above named been afflicted with any disease, illness, lameness, or received any injuries in the past 12-month period?  Yes  No If so, give details: \_\_\_\_\_
7. Is any animal named above to be used as a hunter/jumper/eventer or for racing?  Yes  No
8. Are the eyes, legs and feet of every animal named above in normal condition?  Yes  No
9. Has any animal named above ever had colic or indigestion?  Yes  No  
If so, how often? \_\_\_\_\_ When was the last attack? \_\_\_\_\_  
Give cause of attack, if known: \_\_\_\_\_
10. How many animals did you lose by death in the past 3 years? \_\_\_\_\_ Cause of death? \_\_\_\_\_  
Date of death: \_\_\_\_\_ Insured amount paid \$ \_\_\_\_\_
11. How many other animals of this type do you own? \_\_\_\_\_
12. Was the purchase price:  Cash  Trade  Both If any part trade, state what is consisted of, and state what amount of cash was paid: \_\_\_\_\_
13. Do you understand that it is required under policy to give notice as soon as reasonably possible by telephone of any ILLNESS, INJURY, DISEASE OR DEATH or your claim may be denied, and do you agree to do so?  Yes  No
14. Has any other company ever rejected an application for insurance or canceled a policy on any of the herein described animals?  Yes  No Explain: \_\_\_\_\_
15. Have any of the animals listed herein been previously injured?  Yes  No  
If so, were any claims submitted and/or paid?  Yes  No

**DECLARATIONS**

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I declare to the best of my knowledge and belief that the animal or animals listed on the above schedule to be in normal healthy sound condition. I further declare that during the past policy year, the above listed animals have been free from any ILLNESS, INJURY, DISEASE OR ACCIDENT. I understand and agree that this application shall be the basis of the insurance contract, and if anything be falsely stated or information withheld to influence the company's decision, the insurance contract will be null and void. I, the undersigned, hereby apply to insure the above mentioned animals owned to me, subject to the terms and conditions of the policy to be issued, and I declare that to the best of my knowledge and belief, the above statements are true and complete, and that I have not withheld any material information. Signing this form does not bind the applicant to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and if anything be falsely stated or information withheld to influence the company's decision, the insurance contract will be null and void.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date Signed

## Statement of Health

Effective Date _____	
Insured Name _____	Policy # _____
Address _____	Phone _____

**Description of Horse(s):**

1. Name of Animal	Breed	DOB	Sex	Use	Amount of Insurance
2. Name of Animal	Breed	DOB	Sex	Use	Amount of Insurance
3. Name of Animal	Breed	DOB	Sex	Use	Amount of Insurance

**Questions: Please answer the following:**

1. Is the horse currently sound and healthy for the intended use? \_\_\_\_\_
2. Does the horse have any conformational problems or defects, illness or disease, lameness, injury or physical disability including but not limited to laminitis/founder, OCD, neurological disorders, navicular disease and/or degenerative disease? \_\_\_\_\_
3. Has the horse had any colic or gastro-intestinal disorders and if yes, provide date(s)? \_\_\_\_\_  
 \_\_\_\_\_  
 a. If a surgical correction was made, was there a resection? \_\_\_\_\_
4. Has the horse been nerved or received any surgical treatment for lameness? \_\_\_\_\_
5. Has the horse been examined or treated by a veterinarian for anything other than routine care? \_\_\_\_\_  
 \_\_\_\_\_
6. Has the horse undergone diagnostic ultrasound or x-rays, or received any joint injections, any type or medication long or short term, or preventative treatments? \_\_\_\_\_
7. If "yes" was answered to any of the above questions, please provide details below:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
8. If applicable has the horse been tested for HYPP, HERDA, SCIDS, or any other genetic abnormality?  
 \_\_\_\_\_ Results \_\_\_\_\_

Statement of Health: I declare to the best of my knowledge and belief the animal or animals listed on the above schedule to be in normal healthy sound condition. I further declare that during the past policy period the above listed animals have been free from any illness, injury, disease or accident. I understand and agree that this renewal certification shall be the basis of the insurance contract and if anything is falsely stated or any information is withheld to influence the company's decision to renew the insurance policy, the insurance contract will be null and void.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## CORE PAYMENT OPTION FORM

Please select only one payment option. Return form with completed application. Print legible.

Applicant's Name\* \_\_\_\_\_

Address\* \_\_\_\_\_ City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip\* \_\_\_\_\_

Phone\* \_\_\_\_\_ Fax \_\_\_\_\_

Email\* \_\_\_\_\_ \*required

**Invoices will be emailed to client and are due within 30 days of the Bill Date.  
Minimum \$4 installment fee applies to all invoices**

\_\_\_ Annual- 1 installment

(Available for annual premiums under \$500)

\_\_\_ Semi-Annual: 2 equal installments

(Available for annual premiums under \$500)

\_\_\_ Quarterly: 4 equal installments

(Available for annual premiums over \$500)

**Payment instructions will be sent with the Bill and can be made by check, wire transfer or credit/debit cards.**