

ANIMAL MORTALITY APPLICATION for HORSES



Producer's Name _____ Agency Code _____ Mail Address _____ City, ST, Zip _____ Phone _____ Fax _____ E-mail Address _____	Applicant's Name _____ Mail Address _____ City, ST, Zip _____ Phone _____ Fax _____ E-mail Address _____ Policy Term Desired (maximum term 12 months) _____
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Individual
 Partnership
 Corporation
 Joint Venture
 Limited Liability Corp.
 Other

Proposed Effective Date _____ New Policy _____ Endorsement (Policy Number) _____ Pay Plan Yes No
 (Coverage begins on the date of acceptance by the Company)

PLEASE READ: If you submit an INACCURATE an and/or INCOMPLETE Application, the missing information will delay your coverage and the inaccurate information will result in claim denials and/or coverage reductions. The insurance you are applying for with this Application DOES NOT and WILL NOT cover Pre-Existing Conditions.

Horse Name	Date of Birth	Date of Purchase	*Purchase Price (Stud fee if raised)	*Requested Limit of Insurance
Identification (Sire/Dam, Registration, Tattoo#, Microsoft, or Pictures if unregistered)			Sex (Stallion, Mare, Colt, Filly, Gelding)	Breed
Primary Stable Location:		All Uses		

****All Limits of Insurance are subject to company approval***

*For a Requested Limit of Insurance that does not equal the Purchase Price, complete and attach a Substantiation of Value.

Type of Coverage Requested		
Mortality-Full	Major Medical \$10,000	Increase emergency colic \$7500
Mortality-Limited	Major Medical \$15,000	Increase emergency colic \$10,000
Major Medical \$5000	AS&D (Stallion Infertility)	Colic treatment \$10,000
Major Medical \$7500		Overseas Transit
		Other
1. Was a pre-purchase exam completed? If yes, please attach a copy of the examination results		
	Y	N
2. Has the horse been examined or treated by a veterinarian for any accident, injury, sickness disease, and or lameness within the last 24 months? If Yes, please explain		
	Y	N
3. Is the horse currently free of lameness and healthy without the use of drugs? If No, please explain		
	Y	N
4. Has the horse undergone an ultrasound, bone scan, gastroscopes, or x-rays within the last 24 months? If Yes, please explain		
	Y	N
5. Does the horse have any past conformational problems or defects, illness or disease, lameness, injury, or physical disability including but no limited to: laminitis/founder, OCD, neurological disorders (e.g. EPM), navicular disease, kissing spine, arthritis, and/or degenerative joint disease? If Yes, please explain		
	Y	N
6. Has the horse and a neurectomy or received any treatment for lameness? If Yes, please explain		
	Y	N
7. Has the horse received any long-or short-term medication or any preventative treatments in the last 24 months? If Yes, please explain		
	Y	N
8. Had the horse received any joint injections in the last 24 months? If Yes, Which Joints? How Often? Names of Meds?		
	Y	N
9. Has the horse had any colic, colic surgery, impaction, gastric ulcers, or intestinal disorder with the last 24 months? If Yes, please explain		
	Y	N

10. If a mare, is the mare due to foal any time during the requested Policy Period? If yes, please give: Estimated Foaling Date: _____ Number of Previous Foals _____ Stud Fee _____	Y	N
11. If a mare, has the mare ever experienced birthing difficulties? If Yes, please explain	Y	N
12. Does the horse have an ancestor know to carry HYPP? If Yes, please check the test results; If No, please move on to question 13. Yes No If No, please explain a. Has the horse been HYPP tested? If Yes, please check the test results. N/N N/H H/H b. Please check the HYPP test results of the horse's Sire and Dam. Sire: N/N N/H H/H Unknown Dam N/N N/H H/H Unknown c. Has the horse ever shown any HYPP signs or symptoms?	Y	N
13. Will the horse be observed and cared for daily Yes No If No explain:		
14. Who was the horse acquired from?		
15 Are you the sole owner of the horse? Yes No, If No, provide the other owner's % of interest, name and address		
16. Loss Payee(s) _____ (Name and Adress)		
17. Method of payment? Cash Check Trade Other If Trade, provide signed trade agreement		
18. Is the horse leased? Yes No If Yes, please attach the copy of the leases(s).		
19. Is there or has there ever been any insurance on the horse that is similar to any insurance available on this Application Yes No If Yes, provide the carrier Expiration date: _____ Amount /Type of Coverage _____ If Yes, Attach the Declarations Page, Schedule and Loss Runs		
20. Has any insurance carrier ever canceled, non-renewed or refused to insure an horse(s) in which you have or had a insurable interest? Yes No If Yes, provide details: (Not applicable in MO) _____		
21. Have you lost any horse in the last 5 years (whether insured or not) or have any medical/surgical or colic claims been filed on the above listed horse? Yes No If yes, give date, cause, and explain		
22. Name, address, and telephone number of horse's primary licensed veterinarian:		
23. Do you understand that the insurance policy you are applying for requires you to give the Company Immediate notice of any covered animal's death, injury, sickness, or disease, along with a description of the condition and the name of the attending veterinarian? Do you also understand that failure to give this immediate notice may result in the denial of a claim? Yes No		
24. If horse is not currently insured, why are you choosing to insure now?		
25. If horse is a breeding stallion, how is breeding done? (Live Cover, Pasture Breeding, Collection)		
26. If horse is a breeding mare, how is she bred? (Carrying foal, flushed, not carrying, ICSI)		
27. Is horse currently up to date on worming and vaccinations as recommended by a Vet?	Y	N

If you re requesting a limit of insurance that is more than the purchase price, please provide justification of value. (Training cost, Winnings etc.)

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT. (Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS, IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

APPLICANT'S SIGNATURE

DATE: (Must be no more than 30 days prior to policy effective date)

PRODUCER'S SIGNATURE

PRODUCER'S NAME (Please Print)

STATE PRODUCER LICENSE NO.
(Required Florida)