

ANIMAL MORTALITY APPLICATION for HORSES

(Minimum Earned Policy Premium \$250.00)



Producer's Name <u>Northwest Insurance, LLC</u>	Applicant's Name _____
Mail Address <u>200 North 3rd Ave</u>	Mail Address _____
City, ST Zip <u>Purcell, OK 73080</u>	City, ST Zip _____
Phone <u>800-828-0279</u>	Phone _____
Fax <u>405-494-8060</u>	Fax _____
E-mail Address <u>denise@nweins.com</u>	E-Mail Address _____
<u>www.northwestequineinsurance.com</u>	

☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Limited Liability Corp. ☐ Other _____

Proposed Effective Date: _____ ☐ New Policy ☐ Endorsement _____ (Policy Number) _____
(Coverage begins on the date of acceptance by the Company) (Available on Premiums over \$500)

Installment Payment Plans? ☐ Yes ☐ No

A. Animal Name	Date of Birth	Date of Purchase	Purchase Price (or stud fee if raised)	Requested Limit of Insurance
<u>Identification</u> (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	<u>Sex</u> (Stallion, Mare, Colt, Filly, Gelding)	<u>Breed</u>	<u>Use</u>	
<u>Primary Stable Location:</u>				
B. Animal Name	Date of Birth	Date of Purchase	Purchase Price (or stud fee if raised)	Requested Limit of Insurance
<u>Identification</u> (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	<u>Sex</u> (Stallion, Mare, Colt, Filly, Gelding)	<u>Breed</u>	<u>Use</u>	
<u>Primary Stable Location:</u>				

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:				
A B	A B	A B		
☐ Mortality - Full	☐ Major Medical \$10,000	☐ Increase emergency colic \$7,500		
☐ Mortality - Limited	☐ Major Medical \$15,000	☐ Increase emergency colic \$10,000		
☐ Major Medical \$5,000	☐ Surgical _____	☐ Colic treatment \$10,000		
☐ Major Medical \$7,500	☐ AS&D (Stallion Infertility)	☐ Overseas Transit		
		☐ Other _____		
			Horse A	Horse B
			Y N	Y N
1.	Was a pre-purchase exam completed? If Yes, please send a copy for your file.		☐ ☐	☐ ☐
2.	Has the horse seen a veterinarian within the last year? If yes, explain.		☐ ☐	☐ ☐
3.	Is the horse currently free of lameness and healthy without the use of drugs? If no explain.		☐ ☐	☐ ☐
4.	Has the horse undergone diagnostic ultrasound, bone scan, or x-rays within the last 36 months? If yes explain.		☐ ☐	☐ ☐
5.	Does the horse have any past conformational problems or defects, illness or disease, lameness, or injury or physical disability including, but not limited to: laminitis/founder, OCD, neurological disorders (e.g. EPM) navicular disease, and/or degenerative joint disease? If yes explain.		☐ ☐	☐ ☐
6.	Has the horse been nerved or received any treatment for lameness? If yes explain.		☐ ☐	☐ ☐
7.	Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 36 months? If yes explain		☐ ☐	☐ ☐
8.	Has the horse had any colic, colic surgery, impaction, or intestinal disorder ever? If yes explain.		☐ ☐	☐ ☐
9.	Is the horse due to foal any time during the requested Policy Period? If yes, please give: Estimated Foaling Date: _____; Number of Previous Foals: _____; Stud fee: _____		☐ ☐	☐ ☐
10.	Has the horse ever experienced birthing difficulties? (Mares only)		☐ ☐	☐ ☐
11.	Does the horse have an ancestor known to carry HYPP? If No, please move on to question 12.		☐ ☐	☐ ☐
a.	Has the horse been HYPP tested? If Yes, please check the test results. N/N ☐ A ☐ B N/H ☐ A ☐ B H/H ☐ A ☐ B		☐ ☐	☐ ☐
b.	Please check the HYPP test results of the horse's Sire and Dam. Sire: N/N ☐ A ☐ B N/H ☐ A ☐ B H/H ☐ A ☐ B Unknown ☐ A ☐ B Dam: N/N ☐ A ☐ B N/H ☐ A ☐ B H/H ☐ A ☐ B Unknown ☐ A ☐ B		☐ ☐	☐ ☐
c.	Has the horse ever shown any HYPP signs or symptoms?		☐ ☐	☐ ☐

12.	Will the horses be observed and cared for daily? ☐ Yes ☐ No If No, explain: _____
13.	Who was each horse acquired from?
14.	Are you the sole owner of the horses? ☐ Yes ☐ No If No, provide other owner's % of interest, name and address:
15.	Loss Payees: _____ (Name and Address)
16.	Name, Address and Phone Number of person(s) giving care, custody, and control of horse(s) if other than the named insured: _____ _____
17.	If the purchase price was not paid entirely in cash, please describe the transaction in detail.
18.	Are the horses leased to others? ☐ Yes ☐ No If yes please attached a copy of the lease(s).
19.	Is there any other insurance on the horses? ☐ Yes ☐ No If Yes, provide the carrier name: _____ Expiration Date: _____ Amount of coverage: _____
20.	Has any insurance carrier ever canceled, non-renewed or refused to insure any horse in which you have or had an insurable interest? ☐ Yes ☐ No If yes, provide details: (Not application in MO) _____
21.	Have you lost any horse in the last 5 years (whether or not insured) or have any medical/surgical or colic claims been filed on the above listed horse? ☐ Yes ☐ No If Yes, give date, cause, value and explain:
22.	Name, address, and telephone number of the 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)

Please provide explanation/details for any "Yes" answers to questions 2,4,5,6,7,8,9,and 11C or any "No" answers to questions 3.

A Vet exam may be required to bind coverage.

If you are requesting a limit of insurance that is more than 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 AGENT'S 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 in Florida)