

**EQUINE MORTALITY APPLICATION**

Desired effective date: \_\_\_\_\_

Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Resident Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Farm Name & Address \_\_\_\_\_  
Trainer Info (If applicable) Name \_\_\_\_\_ Phone Number \_\_\_\_\_

|  |  |   |  |
|--|--|---|--|
| <b>Please select coverage desired:</b>   |  |   |  |
| <input checked="" type="checkbox"/> Mortality (required)   | <input type="checkbox"/> Surgical Only | <input type="checkbox"/> Colic Only         | <input type="checkbox"/> Territorial Extension/ Transit        |
| <input type="checkbox"/> Major Medical (includes surgical/colic) Limits: _____ \$7,500 _____ \$10,000 _____ \$15,000 | <input type="checkbox"/> Stallion ASD  | <input type="checkbox"/> Medical Assistance | <input type="checkbox"/> Loss of Use (prior approval required) |
|  |  | <input type="checkbox"/> Accident & Illness | <input type="checkbox"/> Other _____                           |

| <u>Horse Name (if un-named list dam)</u> | <u>Breed</u> | <u>DOB</u> | <u>Sex</u> | <u>Use</u> | <u>Date Acquired</u> | <u>Purchase Price</u> | <u>*Requested value</u> |
|--|--------------|------------|------------|------------|----------------------|-----------------------|-------------------------|
| 1. _____                                 | _____        | _____      | _____      | _____      | _____                | _____                 | _____                   |
| 2. _____                                 | _____        | _____      | _____      | _____      | _____                | _____                 | _____                   |
| 3. _____                                 | _____        | _____      | _____      | _____      | _____                | _____                 | _____                   |

- \*AMOUNT OF INSURANCE REQUESTED IS SUBJECT TO COMPANY ACCEPTANCE AND MUST BE JUSTIFIED*
- Are any of the above horses being leased, financed, or on trial? \_\_\_\_\_ What is the lease fee? \_\_\_\_\_  
*If yes submit a copy of your Agreement.* (Coverage will not be bound without this documentation.)
  - Is there any other insurance on any of the above animals? \_\_\_\_\_ Have you had insurance on any of the above animals before? \_\_\_\_\_  
If no, reason for insuring now \_\_\_\_\_  
If yes, were there any losses/claims on previous policy? \_\_\_\_\_
  - Are any of the horses above being schooled /used over fences for show or pleasure ? \_\_\_\_\_  
If eventing, circle what level you will be competing in: Below Preliminary OR Preliminary & Above
  - If any of the above horses is a mare in foal, name covering stallion & stud fee paid \_\_\_\_\_
  - If raised/homebred foal, give stud fee and name of sire & dam \_\_\_\_\_
  - Has any animal named above been afflicted with any disease, illness or injury in the past 12-month period? \_\_\_\_\_
  - Are eyes, legs and feet of every animal named above in normal condition? \_\_\_\_\_
  - Has any animal named above ever had colic or indigestion? \_\_\_\_\_ If so, when was the approximate month and year of the last attack?  
\_\_\_\_\_ How did it resolve? \_\_\_\_\_
  - How many horses did you lose by death in the last 3 years? \_\_\_\_\_, From what? \_\_\_\_\_ Insured amount paid \$ \_\_\_\_\_
  - Do any of the above horses have an ancestor known to carry HYPP? Yes \_\_\_\_\_ No \_\_\_\_\_ Status (N/N, N/H, H/H) \_\_\_\_\_
  - Was purchase price cash, trade or both? \_\_\_\_\_ If trade please describe \_\_\_\_\_
  - Has any company ever rejected an application for insurance or cancelled a policy on any of the herein-described animals? \_\_\_\_\_  
If yes, Describe \_\_\_\_\_

I, the undersigned, hereby apply to insure the above mentioned animals owned / leased by 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 insurance company's decision, the insurance contract will be null and void. Furthermore, by signing this form I understand that it is required under the policy to give IMMEDIATE NOTICE by telephone of any ILLNESS, INJURY, DISEASE OR DEATH or my claim may be denied.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
*This form must be returned to our office within 30 days of signature date.*