



EQUISPORT INSURANCE AGENCY, INC.
 P.O. Box 269, Bloomfield Hills, MI 48303
 (800) 432-1215 • (248) 644-1215 • Fax (248) 644-1404
 www.equisportagency.com



Application for Horse Mortality

(Minimum premium \$150 fully earned)

How To Apply for New or Renewal Coverage

- Please read carefully answering all of the questions and sign and date the application at the bottom of the page.**
- You will need to complete the Statement of Health section and sign and date where indicated.
- Premium payment. Call your Equisport representative to determine your premium payment.
- Mail or fax your application and Health Statement to Equisport. Coverage is effective once the completed and signed application, Health Statement, and premium payment is received and approved by our underwriters. The application and Statement of Health must be completed *no more than 30 days prior* to receipt in our office.

<p>SECTION I (To be Completed by Owner or Agent) NAMED INSURED:</p> <p>Client Name(s) _____</p> <p>Address: _____ _____ _____</p> <p>Telephone # (H) _____ (W) _____</p> <p>New Business <input type="checkbox"/> Renewal Business <input type="checkbox"/> Additional Coverage <input type="checkbox"/></p> <p>EMAIL: _____</p>	<p>Choose Coverage and Optional Coverages:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Coverages</th> <th style="text-align: center;">Horse #1</th> <th style="text-align: center;">#2</th> </tr> </thead> <tbody> <tr> <td>Full Mortality</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Specified Perils</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td colspan="3"><i>Additional Coverage Options:</i></td> </tr> <tr> <td>Major Medical & Surgical</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Loss Of Use</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Surgical Only</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> <tr> <td>Other: _____</td> <td align="center"><input type="checkbox"/></td> <td align="center"><input type="checkbox"/></td> </tr> </tbody> </table>	Coverages	Horse #1	#2	Full Mortality	<input type="checkbox"/>	<input type="checkbox"/>	Specified Perils	<input type="checkbox"/>	<input type="checkbox"/>	<i>Additional Coverage Options:</i>			Major Medical & Surgical	<input type="checkbox"/>	<input type="checkbox"/>	Loss Of Use	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Only	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Coverages	Horse #1	#2																							
Full Mortality	<input type="checkbox"/>	<input type="checkbox"/>																							
Specified Perils	<input type="checkbox"/>	<input type="checkbox"/>																							
<i>Additional Coverage Options:</i>																									
Major Medical & Surgical	<input type="checkbox"/>	<input type="checkbox"/>																							
Loss Of Use	<input type="checkbox"/>	<input type="checkbox"/>																							
Surgical Only	<input type="checkbox"/>	<input type="checkbox"/>																							
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>																							

HORSES TO BE INSURED: (Be sure the numbers correspond to the horses and coverages selected above)

HORSE #	NAME & REG. #	BREED	YEAR BORN	SEX	USE	PURCHASE*		AMOUNT DESIRED
						DATE	AMNT	
1								
2								

***If amount desired is greater than purchase price, please provide a "Justification Of Value" statement.**

Are you the sole owner or a leasee? _____ Give name and address of other interest _____ (If leased, submit agreement)

Is there any other insurance on any of the animals listed herein? _____

Chiefly kept on premises known as _____

Name and address of trainer: _____

Name, address of usual veterinarian: _____

Has any animal listed above ever been afflicted with any disease or sickness or received any injury during the past 12 months?
 _____ If yes, give details: _____

Has any listed animal ever had colic? _____ If yes, give details: _____

If mare in foal, name covering stallion & stud fee paid? _____ If raised foal, give stud fee _____

Have you lost any animal by death or theft in your care or ownership in the last 3 years? _____ Details: _____

Have you been paid any claim on livestock? _____ If yes, give details: _____

Has any company ever rejected an application for insurance or cancelled a policy whether listed or not? _____

Do you understand that it is required under the policy to give **immediate** notice by the telephone of any **ILLNESS, INJURY, DISEASE OR DEATH, OR YOUR CLAIM** may be denied and do you agree to do so? _____

I, the undersigned, hereby apply to insure the above mentioned animal(s) owned 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 application to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy to 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.

Date: _____ Signature: _____

OWNER MUST → COMPLETE BACK



EQUISPORT AGENCY, INC.

P.O. Box 269 Bloomfield Hills, Michigan 48303
(248) 644-1215 (800) 432-1215 Fax: (248)644-1404

STATEMENT OF HEALTH

Name of Insured: _____ Phone Number: _____

Address: _____

Name of Horse: _____ Breed: _____ Height: _____ Sex: _____ Date of Birth _____

Horse's Exact Use: _____ Level: _____ Insured Value +: _____
+ insured amount should not exceed the horse's current fair market value.

Last Year's Policy Number: _____ Desired Effective Date: _____

Loss Payee or Additional Insured Name: _____

1. Is the horse currently sound and healthy for the use intended? Yes No
2. For all Quarter Horses, Appaloosas, or Paint horses.
Does the horse have a ancestor known to carry HYPP? Yes No
If "Yes" is answered, please indicate the HYPP status. (Circle one.) N/N N/H H/H
(Note: Coverage will not be considered without the disclosure of HYPP status.)
3. Does the horse have any past or present conformation problems, defects or ailments, illness or disease, lameness, injury or physical disability including but not limited to: laminitis/founder, OCD, neurological disorders, navicular disease, and/or degenerative joint disease? Yes No
4. Has the horse had any colic or intestinal disorder within the last 36 months? Yes No
5. Has the horse been nerved or received any surgical treatment for lameness? Yes No
6. Has the horse been examined or treated by a veterinarian for other than routine care within the last year? Yes No
7. Has the horse undergone diagnostic ultrasounds, X-rays, or bone scans within the last 36 months? Yes No
8. Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? Yes No
9. Does the horse receive any other medications/supplements? Yes No
10. Are there any other current or prior health conditions to which the horse has been exposed? Yes No

If "yes" was answered to any question(s) 3 through 10, please provide details below.

I understand and agree that the policy to be issued shall be funded upon the statements contained herein and prior policy information and this statement shall be the basis of the contract and if anything be falsely stated, or information withheld, to influence the Company's decision, the insurance shall be null and void.

Signature of owner(s) of above named animal

Date: _____
(must be no more than 30 days prior to policy effective date)