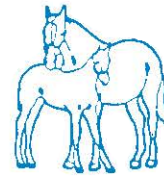


Equine Insurance Center
 PO Box 940
 Oak Ridge, NC 27310
 Direct: 336-252-3950 or Toll Free:
 888-335-3338 Fax: 1-336-622-7783
 rgotshall@equineinsurancecenter.com
 tmiller@equineinsurancecenter.com



NO MORTALITY APPLICATION WILL BE CONSIDERED IF NOT FULLY COMPLETED AND SIGNED BY THE INSURED
 (Completion of Application does not bind Company to risk)

New Policy Add to Existing Policy # _____ Proposed Effective date: _____

1. Named Insured – Full Name(s)/DBA: _____

Individual Joint Venture Organization Corporation Partnership Syndication

2. Address: _____

City: _____ State: _____ County _____ Zip: _____

3. Home #: _____ Business #: _____ Cell #: _____

Email Address: _____ (Company/Agent use for Claims/Policy Info Distribution)

4. **ANIMAL(S) TO BE COVERED:** (Copy for additional horses) *M=Mare G=Gelding C=Colt S=Stallion F=Filly*

#	Name/Registration No.*	Breed	Date of Birth	Sex	Exact Use	Purchase Date	Purchase Price	Mortality Amount	Rate <small>Co Use Only</small>
1									

Stud Fee (Homebred Foals): \$ _____ Sire's Name: _____ Dam's Name: _____

Color & Markings Description: _____

Optional Coverage: **MAJOR MEDICAL (Includes Surgical) **** \$5,000 \$7,500 \$10,000 \$15,000
 SURGICAL ONLY ** \$5,000 \$7,500 \$10,000
 60% FULL LOSS OF USE **60% ACCIDENT LOSS OF USE** (Requires carrier vet examination forms)
 INFERTILITY **INTERNATIONAL TRANSIT** **WORLDWIDE EXTENSION**

2	Name/Registration No.*	Breed	Date of Birth	Sex	Exact Use	Purchase Date	Purchase Price	Mortality Amount	Rate

Stud Fee (Homebred Foals): \$ _____ Sire's Name: _____ Dam's Name: _____

Color & Markings Description: _____

Optional Coverage: **MAJOR MEDICAL (Includes Surgical)**** \$5,000 \$7,500 \$10,000 \$15,000
 SURGICAL ONLY ** \$5,000 \$7,500 \$10,000
 60% FULL LOSS OF USE **60% ACCIDENT LOSS OF USE** (Requires carrier vet examination forms)
 INFERTILITY **INTERNATIONAL TRANSIT** **WORLDWIDE EXTENSION**

*Name of sire and dam for unnamed foals. Un-registered horses require current photographs and/or Brand Inspection or Coggins Certificate ***For multiple horses, please provide horse # for details to any questions answered Yes on the application****

5. a.) Are you the sole owner of the horse(s) listed? Yes No b.) Any Lease Agreements? Yes No (provide copy)

c.) Name & address of additional insured/loss payee/lienholder on listed horse? _____

6. a.) Price paid: cash trade or both Details: _____ (JOV required if Insd Amt exceeds Price Paid)

b.) Acquired from: _____

7. Do you own other horses not listed above? Yes No If yes, how many? _____

8. Has the listed horse(s) been previously insured? Yes No If yes, provide policy expiration date, insured amount, and company's name: _____

9. Have you filed any claims or had any Insurance losses in the last 3 years? Yes No If yes, give date, cause of loss, health condition, value of animal or amount of paid claim as explanation: _____

10. Has horse(s) had any previous colic, colic surgery, impaction, gastro-intestinal disorders or ulcers? Yes No
If yes please provide dates/history: _____
11. To your knowledge, has any horse(s) listed suffered any accident, illness, injury, disease or lameness and had any veterinary treatment? Yes No If Yes, details: _____
12. Any horse(s) listed received any medication(s), other than preventative annual vaccines, for any accident, illness, injury, disease or lameness condition? Yes No Reasons: Preventative Maintenance Treatment If yes, provide specifics: 1) horse 2) condition 3) applicable limb & joint 4) medication 5) frequency 6) duration _____
13. Does the horse have any pre-existing conditions or history of lameness due to conformational problems or birth defects, injury, illness or disease, or physical disability including but not limited to: Laminitis/Founder, Nerving, Osteochondrosis, neurological disorders i.e. HYPP, EPM, Navicular Disease and/or Degenerative Joint Disease? Yes No If Yes, explain and provide history: _____
14. Has the horse(s) required any diagnostics, medical or surgical treatment for lameness within the last 24 months? Yes No If Yes, explain and provide history: _____
15. Any congenital or hereditary birth defects known to exist in horse(s) such as (neurologic, skeletal, spinal, conformational problems)? Yes No. If yes, Condition: _____

USE & MANAGEMENT SECTION:

16. a.) Person(s) or having the care, custody or control of listed horse(s)? _____
b.) Location where listed horse(s) will be boarded? _____
c.) Years experience of caretaker? _____ Are premises suitable and safe-guarded for horses? Yes No
17. Name and contact information of regular Veterinarian: _____
18. How far to the closest surgical facility? _____ Is your regular Vet on staff there? Yes No
Is emergency transportation readily available for transport to Veterinarian care? Yes No
19. Is/Are horse(s) currently, and will remain, on a Vaccine and Deworming program recommended by your regular Vet? Yes No. If No, explain: _____
20. Is the horse due to foal any time during the proposed policy period? Yes No If yes, foaling date: _____ Any history of unsatisfactory foaling? _____
21. Was a pre-purchase exam done? Yes No **If yes, results of the pre-purchase must be received**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

I understand, and agree to, **IMMEDIATELY NOTIFY** the Company upon any injury, illness, surgery, disease or death of an animal, **and further that other reporting time conditions apply in the event of a claim hereunder.** I also understand that in the event of the death of an insured horse, a postmortem exam by a qualified veterinarian must be provided at my expense.

I/we declare that I/we have read the above Fraud Warning and that all the above statements made in this application are true to the best of my/our knowledge and belief and that this application shall form the basis of the contract between me/us and the insurer/Company and that I/we will accept and abide by the terms and conditions contained in the policy to be issued. If anything be falsely stated, or information withheld, to influence the Company's decision, then coverage under the policy may be jeopardized if the Company has been prejudiced and the insurance can be canceled with the appropriate length of notice per state statute and Company be released from any liability in connection with the claim.

Applicant's Signature: _____ Date: _____

Agent's Signature: _____ Date: _____

****If you have had prior Insurance coverage with another agency or carrier please request a 3 year loss report from that carrier/agency to accompany this application as this is a requirement****