



APPLICATION For Equine Mortality Insurance

NEW
 RENEWAL
 ADD TO CURRENT POLICY
 DESIRED EFFECTIVE DATE _____

Applicant's Name: (Owner or Lessee) _____ DBA _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone Number: Home: _____ Business: _____ Cell: _____
 E-mail Address: _____ FAX Number: _____
 Membership: US Equestrian # _____ OR Affiliate Name _____ # _____

Please note: Current Association membership is required for coverage. Contact us for affiliate verification.

How did you hear about us? Association Referral Internet Ad Other _____

Name of Horse	Breed	Sex*	Age or Birthdate	Purchase Price or Stud Fee	Purchase Date	Insured Value**	Use
1							
2							
3							

* M = MARE G=GELDING S=STALLION

**JUSTIFICATION OF VALUE MUST BE PROVIDED FOR ALL NEW AND RENEWAL POLICIES

Please list sire/dam for all horses above (if known):

1. SIRE _____ DAM _____

2. SIRE _____ DAM _____

3. SIRE _____ DAM _____

Please select optional coverage for each horse. (Optional coverage can NOT be added to the policy mid-term)

	Major Medical	Emergency Surgical Only	Loss of Use	Terrorism
	SURGICAL COVERAGE INCLUDED	LIFE-SAVING SURGERY ONLY	SHOW/BREEDING HORSES ONLY	ADD \$51.50 per horse
1	<input type="checkbox"/> \$10,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$10,000 limit/\$500 deductible/no co-pay <input type="checkbox"/> \$15,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$15,000 limit/\$500 deductible/no co-pay	<input type="checkbox"/> \$2,500 limit/no deductible <input type="checkbox"/> \$7,500 limit/no deductible	<input type="checkbox"/> 60% Accidental External Injury VET CERTIFICATE AND LOSS OF USE APPLICATION REQUIRED	<input type="checkbox"/>
2	<input type="checkbox"/> \$10,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$10,000 limit/\$500 deductible/no co-pay <input type="checkbox"/> \$15,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$15,000 limit/\$500 deductible/no co-pay	<input type="checkbox"/> \$2,500 limit/no deductible <input type="checkbox"/> \$7,500 limit/no deductible	<input type="checkbox"/> 60% Accidental External Injury VET CERTIFICATE AND LOSS OF USE APPLICATION REQUIRED	<input type="checkbox"/>
3	<input type="checkbox"/> \$10,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$10,000 limit/\$500 deductible/no co-pay <input type="checkbox"/> \$15,000 limit/\$250 deductible/20% co-pay <input type="checkbox"/> \$15,000 limit/\$500 deductible/no co-pay	<input type="checkbox"/> \$2,500 limit/no deductible <input type="checkbox"/> \$7,500 limit/no deductible	<input type="checkbox"/> 60% Accidental External Injury VET CERTIFICATE AND LOSS OF USE APPLICATION REQUIRED	<input type="checkbox"/>

*for additional horses, attach a new page.

- Please note that additional premium applies for ALL coverages listed above.
- Major Medical not available on horses over 15 years old
- Major Medical & Emergency Surgical premiums are fully earned if cancelled prior to anniversary date
- \$150 Minimum Earned Mortality Premium applies if cancelled prior to anniversary date.

PLEASE READ ALL QUESTIONS BELOW CAREFULLY, AND REFER TO HORSES BY NAME OR NUMBER.

1. Are you the sole owner of the horses? YES NO
 If NO, list name of co-owner, mortgage holder or lessor: _____
2. Are the horses kept on your property? YES NO
 If NO, list stabling address _____
3. List your regular veterinarian's name and phone number _____

If this is a new purchase, a copy of the pre-purchase exam must be included.

4. To the best of your knowledge is/are the above horse(s) at present normal in conformation, eyes, heart, wind and action and in good health and does it/do they, therefore, represent a normal risk for the proposed insurance? YES NO
If NO, provide details _____
5. Are the horses on a regular worming and vaccination program supervised by a veterinarian and have they been vaccinated against West Nile Virus? YES NO
If NO, provide details _____
If YES, provide date of vaccination and dates of follow up boosters: _____
No coverage is afforded for this cause of loss unless the horse has been properly vaccinated
6. Have any animals owned by you ever been stolen? YES NO
If YES, provide details _____
7. Have any horses (including foals) owned by you or in your possession died? YES NO
If YES, provide details _____
8. Have any listed horses ever been unsound in any way or been fired, blistered, nerved, operated on or received treatment for lameness at any time to the best of your knowledge? YES NO
If YES, provide details _____
If YES, has the horse made a partial or complete recovery? _____
9. Have any listed horses ever exhibited any symptoms of or been treated for colic or any other digestive disorder? YES NO
If YES, provide details _____
10. Have any listed horses undergone diagnostic ultrasound, bone scan or x-rays within the last year? YES NO
If YES, provide details _____
11. Has there been any evidence of contagious disease during the past twelve months at the stable/farm where any listed horses have been kept? YES NO
If YES, provide details _____
12. Have any listed horses suffered at any time from melanoma, sarcoids, warts, or any other type of skin growth or disorder?
 YES NO If YES, provide details _____
13. During the last twelve months have any listed horses ever undergone surgery or received attention from any Veterinary Surgeon, Physiotherapist, Chiropractor, Acupuncturist or Homeopathist for any reason other than routine vaccination, preventative care or obstetric work, or received any other form of treatment for remedial purposes including farriery? YES NO
If YES, provide details including recovery status _____
14. Have any listed horses been tested for EPM? YES NO
If YES what method was used and what were the results? _____
15. Have any listed horses received joint injections? YES NO
If YES, provide details _____
16. Have any listed horses been diagnosed with any degenerative condition, including but not limited to: neurological conditions, degenerative joint disease, laminitis, navicular disease, OCD or arthritis? YES NO
If YES, provide details _____
17. Do you intend to castrate any listed colt or stallion within the next 12 months? YES NO
If YES, provide details (reason, date, etc) _____
18. Have any listed horses been insured before? YES NO
If YES, list company and reason for changing _____
If NO, list reason for not insuring _____
19. Do you have any other insurance in force on any listed horse (Including preventative health care programs)? YES NO
If YES, please specify _____
20. Have you ever had any claims, whether the loss was covered or not? YES NO
If YES, provide details and amount paid (if any) _____
21. Has any insurance company ever denied, restricted, or refused to renew, coverage? YES NO
If YES, provide details _____

22. Do you understand that Equisure, Inc. must be notified IMMEDIATELY upon any injury, illness, disease, operation, unsoundness or death? YES NO

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN BELOW.

UNSIGNED OR INCOMPLETE APPLICATIONS WILL BE RETURNED WITH NO COVERAGE BOUND.

- ◆ THE ABOVE ANIMALS ARE OWNED BY ME AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED IN CONNECTION WITH THIS APPLICATION, WHETHER IN MY HAND OR NOT IS TRUE AND I HAVE NOT WITHHELD ANY MATERIAL FACTS. I UNDERSTAND THAT NON-DISCLOSURE OR MISREPRESENTATION OF A MATERIAL FACT WILL ENTITLE UNDERWRITERS TO VOID THE INSURANCE.
(Note: a material fact is one likely to influence acceptance or assessment of this application by Underwriters. If you are in any doubt as to what constitutes a material fact, you should consult Equisure, Inc.) I understand that the signing of this application does not bind me to complete the insurance, but I agree that, should a Contract of Insurance be concluded, this application and the statements made therein shall form the basis of the Contract
- ◆ No coverage will be bound until the completed application is approved by Equisure, Inc. and premium payment is received. Receipt of premium does not imply or bind coverage until the application is approved. If the application is not approved, any paid premium will be refunded. Equisure, Inc. reserves the right to adjust premium based on information submitted in this application. **Please allow a minimum of 5 days for your coverage request to be approved or declined.**
- ◆ **UNSIGNED OR INCOMPLETE APPLICATIONS WILL BE RETURNED. SIGNED FRAUD AND TERRORISM FORMS AND APPROPRIATE HEALTH FORMS MUST BE INCLUDED.**
- ◆ **AGREEMENT OF THE INSURED:** I understand and agree that I or my authorized representative will notify Equisure, Inc. or its Authorized Claims Representative immediately and in writing of any condition arising out of any accident, injury, illness or disease to any insured horse that has been ongoing for fourteen (14) days or more, or any condition arising out of any accident, injury, illness or disease, which has required the attendance of, or treatment by any Veterinarian on two or more occasions. I further understand and agree that any failure to do so on my part or on the part of my authorized representative will render the policy and any claim made against it null and void.
- ◆ **I understand and agree that if I cancel this policy AT ANY TIME, a minimum mortality premium of \$150.00 will be retained by Equisure, Inc. Medical and Surgical premiums are fully earned and non-refundable.**
- **I understand that Equisure, Inc. must be notified IMMEDIATELY upon any injury, illness, disease, operation, unsoundness or death, and I understand that pre-existing conditions are excluded from coverage.**
- THE ABOVE ANIMALS ARE OWNED BY ME AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION PROVIDED IN CONNECTION WITH THIS APPLICATION, WHETHER IN MY HAND OR NOT IS TRUE AND I HAVE NOT WITHHELD ANY MATERIAL FACTS. I UNDERSTAND THAT NON-DISCLOSURE OR MISREPRESENTATION OF A MATERIAL FACT WILL ENTITLE UNDERWRITERS TO VOID THE INSURANCE.
- **SIGNED FRAUD STATEMENT & TERRORISM DISCLOSURE MUST ACCOMPANY THIS FORM, ALONG WITH PREMIUM PAYMENT. UNSIGNED OR INCOMPLETE APPLICATIONS WILL BE RETURNED.**

FRAUD WARNING NOTICES

STANDARD: Any person, who knowingly and with intent to defraud any insurance company or other 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 hereto, commits a fraudulent act, which is a crime, and may subject such person to criminal and civil penalties.

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly, and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MINNESOTA APPLICANTS: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

The insurer shall not offer an optional extension period for this policy in New Mexico.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other 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 guilty of insurance fraud which may subject such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution and confinement in state prisons.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to a civil penalty not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.

THE UNDERSIGNED IS AUTHORIZED BY THE INSURED AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE INSURED OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL APPLICATIONS, AND THE MATERIALS SUBMITTED HERewith ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THE APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY. PROVIDED, HOWEVER, THIS PARAGRAPH DOES NOT APPLY IN THE STATES OF UTAH AND WISCONSIN.

NOTE TO UTAH AND WISCONSIN RESIDENTS: ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE MADE A PART HEREOF PROVIDED THIS APPLICATION AND SUCH MATERIALS ARE ATTACHED TO THE POLICY AT THE TIME OF ITS DELIVERY.

THE INSURED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE INSURED WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SIGNATURE

DATE

Please note that your insurance will be placed under a facility whereby a Profit Commission may be payable to Equisure by the Insurer. Equisure will be paid a commission by the Insurer for the administration of this insurance policy.

**Send completed application with payment, appropriate health form(s), terrorism disclosure, fraud statement and valuation to:
EQUISURE, INC. 13790 E Rice Pl Ste 100 * Aurora, CO * 80015 * 800-752-2472 * FAX 303-614-6967**

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM

You are hereby notified that under the Terrorism Risk Insurance Act of 2002, as amended ("TRIA"), that you now have a right to purchase insurance coverage for losses arising out of acts of terrorism, *as defined in Section 102(1) of the Act, as amended*: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property; or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of an air carrier or vessel or the premises of a United States mission; and to have been committed by an individual or individuals, as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Any coverage you purchase for "acts of terrorism" shall expire at 12:00 midnight December 31, 2014, the date on which the TRIA Program is scheduled to terminate or the expiry date of the policy whichever occurs first, and shall not cover any losses or events which arise after the earlier of these dates.

YOU SHOULD KNOW THAT COVERAGE PROVIDED BY THIS POLICY FOR LOSSES CAUSED BY CERTIFIED ACTS OF TERRORISM IS PARTIALLY REIMBURSED BY THE UNITED STATES UNDER A FORMULA ESTABLISHED BY FEDERAL LAW. HOWEVER, YOUR POLICY MAY CONTAIN OTHER EXCLUSIONS WHICH MIGHT AFFECT YOUR COVERAGE, SUCH AS AN EXCLUSION FOR NUCLEAR EVENTS. UNDER THIS FORMULA, THE UNITED STATES PAYS 85% OF COVERED TERRORISM LOSSES EXCEEDING THE STATUTORILY ESTABLISHED DEDUCTIBLE PAID BY THE INSURER(S) PROVIDING THE COVERAGE. YOU SHOULD ALSO KNOW THAT THE TERRORISM RISK INSURANCE ACT, AS AMENDED CONTAINS A \$100 BILLION CAP THAT LIMITS U.S. GOVERNMENT REIMBURSEMENT AS WELL AS INSURERS' LIABILITY FOR LOSSES RESULTING FROM CERTIFIED ACTS OF TERRORISM WHEN THE AMOUNT OF SUCH LOSSES IN ANY ONE CALENDAR YEAR EXCEEDS \$100 BILLION. IF THE AGGREGATE INSURED LOSSES FOR ALL INSURERS EXCEEDS \$100 BILLION, YOUR COVERAGE MAY BE REDUCED. THE PREMIUM CHARGED FOR THIS COVERAGE IS PROVIDED BELOW AND DOES NOT INCLUDE ANY CHARGES FOR THE PORTION OF LOSS COVERED BY THE FEDERAL GOVERNMENT UNDER THE ACT.

PLEASE 'X' ONE OF THE BOXES BELOW AND TAKE THE ACTION INDICATED

<input type="checkbox"/>	I hereby elect to purchase coverage for acts of terrorism for a prospective premium of \$___51.50 per horse___
<input type="checkbox"/>	I hereby elect to have coverage for acts of terrorism excluded from my policy. I understand that I will have no coverage for losses arising from acts of terrorism.

Policyholder/Applicant's Signature

Print Name

Date



PROFESSIONAL TRAINER STATEMENT

- *This form serves to provide information justifying the value of said animal for insurance purposes.*
- *A qualified trainer who is familiar with the horse and the current market should complete the form.*

Please provide the following information:

Owner (the Insured): _____

Name of Horse: _____

Trainer _____

Address _____ **Phone:** _____

How long have you been a trainer? _____

Professional Qualifications (certifications, breeds and disciplines, other related education):

Familiarity with Horse (how long you have known the horse/owner, professional observations):

Value Estimation and Reasoning: (please provide your professional estimate of this horse's current value in a competitive market):

Additional Comments:

I hereby certify that to the best of my knowledge and belief, the above particulars are true and correct.

Signed: _____ Date: _____

(trainer)

Please return this form to: **Equisure, Inc. 13790 E Rice Pl Ste 100, Aurora, CO 80015**, or fax to: **(303) 614-6967**.



**SUPPLEMENTAL APPLICATION/TRAINER STATEMENT
Justification of Value for New and Renewal Policies or Value Increase Requests**

SHOW and PERFORMANCE HORSES

Horse Name _____ Owner Name _____

NAME OF SHOW	SHOW DATE	RATING	CLASS	PLACE	NUMBER IN CLASS

BREEDING STALLIONS – please complete the following:

NAME	# MARES BOOKED	# MARES BRED LAST SEASON	STUD FEE

BREEDING MARES – please complete the following

NAME	DATE LAST BRED	# OF FOALS	SALE PRICE OF FOAL(S)	CURRENT STALLION	STUD FEE

PLEASE READ AND SIGN THE STATEMENT BELOW

I hereby certify that to the best of my knowledge and belief, the above particulars are true and correct.

SIGNED _____ DATE _____
(owner/trainer)

Veterinarian Certificate of Examination for Mortality Insurance

Horses being examined for insurance should be moved about outside the stall to be observed for any abnormalities in movement or structure. Careful observation and inquiry should be made as to housing conditions and the presence of contagious disease. This Certificate should be completed by the examining veterinarian to the best of his/her ability as a licensed veterinarian. The separate certificates for each horse should be forwarded to Equisure, Inc. without delay. Certificate must arrive at our offices no more than 15 days from the time of examination.

I, _____ do hereby certify that I am a graduate veterinarian holding a current license as such to practice in the State of _____ and that I have examined on this day the following animal:

Name: _____ Age: _____ Color: _____ Sex: _____ Breed: _____

Owned by: _____ Horse's Sire: _____ Dam: _____

Stabled at: _____ () _____

Street Address
City
State
Phone Number

Person having care/control of animal: _____ () _____

Name
Address
Phone Number

Whorls & Markings (natural & acquired)

Front

Rear

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	<u>N/A</u>
Pulse and Respiration Normal?	___	___	Has horse been castrated?	___	___	___
Temperature Normal?	___	___	If so, when? _____			
Eyes clinically normal?	___	___	Any report or evidence of other surgery?***	___	___	___
Heart auscultation normal?	___	___	If mare, is she in foal?	___	___	___
History or evidence of bleeder?	___	___	If male, are both testicles in scrotum?	___	___	___
History or evidence of colic? **	___	___	Any indication of infection or disease?	___	___	___
History or evidence of laminitis?	___	___	Any indication of firing or blistering? **	___	___	___
Any digestive disorder, past or present?	___	___	Any abnormality of the hair coat?	___	___	___
Any evidence of weight loss?	___	___	Any abnormal conformation?	___	___	___
Any evidence of melanoma, sarcoid or other tumors or growths?	___	___	Any signs of neurologic deficit, past or present?	___	___	___

**Any horse that has been nerved at or above the fetlock and any horse that has previously suffered from an attack of colic may not be insurable. Please include full details concerning either condition.

***Any horse that has undergone surgery may be eligible for specific exclusions in coverage.

If any surgery other than a healed castration has been performed, describe type of surgery: _____

If surgery has been performed, has horse clinically recovered? _____

Describe any clinical signs of lameness, abnormal conformation, or other abnormal conditions: _____

How often wormed? _____ Method: _____ Date last wormed: _____

Detail immunization in the past 12 months: _____

Has the horse been vaccinated for the West Nile Virus? _____ Provide date of vaccination and boosters _____

(No coverage is afforded for this cause of loss, unless the horse has been properly vaccinated)

Is stabling adequate? Describe any concerns: _____

Describe any clinical evidence of vices or objectionable habits: _____

Has official E.I.A. Test been run? _____ Date: _____ Lab No.: _____ Result: _____

Has an EPM Test been run? _____ Date: _____ Method: _____ Result: _____

Any signs of neurological deficit at any time, past or present: _____ If yes, what were they and what was the diagnosis? _____

Explanation of abnormal findings and/or additional comments: _____

In your opinion or to your knowledge, are there any additional medical facts that should be brought to the attention of the company?

Are you the regular veterinarian for this horse? _____ If so, have you examined or treated this horse for anything other than preventative medicine in the last year? Please describe: _____

Regular veterinarian's name, address and phone number? _____

How far is the clinic from where the horse is stabled? _____

Is the horse enrolled in any preventative health care programs? _____ If yes, please provide name of program _____

***** FRAUD STATEMENT *****

ANY PERSON WHO KNOWINGLY OR WILLINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE OR INCOMPLETE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIMINAL OFFENSE.

Date & Time of Exam	Signature of Veterinarian	D.V.M.
Office Phone Number	License Number	
Mailing Address		

Veterinary Certificate is not acceptable unless it is received by Equisure, Inc. **within 15 days of Examination.** If you have questions concerning this form, please contact our offices at: (800) 752-2472 * (303) 614-6961 * (303) 614-6967 Fax

Return this form to: **Equisure, Inc., 13790 E Rice Pl Ste 100, Aurora, Colorado 80015**
3-09 revision