

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**

01/08 revision