APPLICATION *For Equine Mortality Insurance*

___ NEW ___ RENEWAL ___ ADD TO CURRENT POLICY DESIRED EFFECTIVE DATE _____

Applicant's Name: (Owner or Lessee) _____

Address: _____City: _____State:_____ Zip:_____

Phone Number: Home:_____Business:_____Cell:_____

E-mail Address: _____FAX Number:_____

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 C=COLT F=FILLY**

****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 Option #1: $7,500 limit $300.00 Deductible	**Annual Premium $300.00**	**Horse #_____**
Major Medical Option #2: $10,000 limit $500.00 Deductible	**Annual Premium$300.00**	**Horse #_____**
Major Medical Option #3: $15,000 limit $500.00 Deductible	**Annual Premium $450.00**	**Horse #_____**

- **Please note that additional premium applies for ALL coverages listed above.**
- **Major Medical not available on horses under 90 days or over 15 years old**
- **Major Medical premiums are fully earned if cancelled prior to anniversary date**
- **$200 Minimum 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. Is the horse currently free of lameness and healthy, without the use of drugs, for the use intended? ___ YES ___ NO
3. Does the horse have any past conformational problems or defects, illness or disease, lameness, injury or physical disability, including but not limited to laminitis/founder, OCD, neurological disorders, tendon or ligament injury, navicular disease and/or degenerative joint disease. ___ YES ___ NO
4. Has the horse had any colic, impaction, colic surgery or intestinal disorder within the last 3 years? ___ YES ___ NO
5. Has the horse been nerved, undergone diagnostic ultrasound, x-ray or MRI or received surgical treatment for lameness? ___ YES ___ NO
6. Has the horse received any joint injections, any type of medication (long or short term) or any preventative treatments in the last 24 months? ___ YES ___ NO
7. Has the horse been examined or treated by a veterinarian for other than routine care within the last 12 months? ___ YES ___ NO
8. Has the horse ever suffered from melanomas, sarcoids or any type of growth? ___ YES ___ NO
9. If Mare, Is she in foal? ___ YES ___ NO
10. If "Yes", give last service date and covering stallion name_____
10. Has horse been vaccinated for West Nile Virus? ___ YES ___ NO

11. For all Quarter Horse, Appaloosas or Paints- Does the horse have ancestor known to carry HYPP? ___ YES ___ NO
    If "Yes", indicate HYPP status (check one) ___ N/N ___ N/H ___ H/H
12. How long have you owned and/or had custody of the horse:_____
13. Do you understand that Equisure, Inc. must be notified IMMEDIATELY upon any injury, illness, disease, operation, unsoundness or death? ___ YES ___ NO

If "Yes" was answered to any question(s) 3 through 7 above, please provide details below. Include onset date, diagnosis, treatment, how condition was resolved and when horse returned to full work._____

_____

_____

_____

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 the Company 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. **Please allow a minimum of 5 days for your coverage request to be approved or declined.**

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- **UNSIGNED OR INCOMPLETE APPLICATIONS WILL BE RETURNED. SIGNED FRAUD AND APPROPRIATE HEALTH FORMS MUST BE INCLUDED, ALONG WITH PREMIUM PAYMENT. UNSIGNED OR INCOMPLETE APPLICATIONS WILL BE RETURNED.**

AGREEMENT OF THE INSURED: 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. 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 premium of $200.00 will be retained by the Company. Major Medical premiums are fully earned.**

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 HAWAII APPLICANTS: For your protection, Hawaii law required you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
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 MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 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 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.
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.
WEST VIRGINIA 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.

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), fraud statement and valuation to:
EQUISURE, INC. 13790 E Rice Pl Ste 100 * Aurora, CO * 80015 * 800-752-2472 * FAX 303-614-6967

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**.

Endorsements to be Included for No Additional Premium
*****Note only ONE will be included******

Please check ONE of the Following Coverages

Option 1 ☐ **Twelve Month Extension Endorsement**

In the event of the death of any horse occurring within 12 months after the expiry of this insurance as a result of any covered accident, illness, injury, disease, and/or disability occurring or manifesting itself and reported to us before the expiration of this insurance, we will pay you in respect to fair market value of the horse up to but not exceeding our limit of liability. ***Certain Limitations Apply***

OR

Option 2 ☐ **Guaranteed Renewal Endorsement**

We guarantee that we will renew mortality coverage as provided on this policy under the Horse Mortality Insurance Policy Provisions. ***Certain Limitations Apply***

INSURED NAME (print): _____ **DATE** _____

INSURED SIGNATURE: _____

This summary of coverage is designed to provide a brief summation of your coverage, subject to the policy provisions, conditions, and exclusions.

*** Please contact us for specific terms and conditions.***

EQUISURE, INC.
13790 E Rice Pl Ste 100 * Aurora, CO * 80015
***TEL 800-752-2472 * FAX 303-614-6967**
www.equisure-inc.com

PAYMENT OPTIONS FORM

Please select only one payment option. Return form with completed application. Print legible.

Applicant's Name* _____

Address* _____ **City *** _____**State*** _____**Zip*** _____

Phone* ( ) _____ **Fax** ( ) _____

Email* _____ **** required***

Select option and complete payment information below.

___ **OPTION 1: Request Quote Only (No payment enclosed)**

___ **OPTION 2: Full Payment**

___ **OPTION 3: Premium Financing (Minimum 30 % Down Payment with Premium Balance Due Financed[1])**

___ **Credit Card** (*check one*): ___ VISA or ___ MasterCard **Amount Authorized $** _____

Name on Credit Card _____

Credit Card # _____-_____-_____-_____

Credit Card Expiration date: __ __/ __ __

Signature as shown on Credit Card _____

We do not accept American Express or Discover

___ **Check or Money Order** (made payable to: *Equisure, Inc.*) - enclosed for financing down payment or full premium of: **$**_____

___ **Premium Financing** is provided through Premium Finance Specialist Corp (IPFS)[2] and is *not* financed by Equisure, Inc. By signing this confirmation as the named insured you authorize a representative of Equisure, Inc. to prepare and sign the Premium Finance Agreement on your behalf and agree to all provisions of the Premium Finance Agreement. A copy of the Premium Finance Agreement will be provided to you. (*Please be advised that interest rates may vary and may exceed 20% APR).* **Minimum 30% down payment (*credit card, check or money order*) required for financing.**

_____ _____

Signature **Date**

___ **Yes, I would like to receive my finance notices, finance invoices and finance statements via email from Premium Financing Specialists, Inc. (IPFS). Please print the name and provide an email address to receive PFS eForms.** [*Note: PFS will continue to utilize the US Postal Service (USPS) for the purpose of legal notifications required by premium financing statutes. These notices will be emailed and also mailed through the USPS].*

_____

Name (please print first and last name)

_____

Email address

[1] Optional Endorsement and Mortality Major Medical premiums must be paid in full and cannot be financed.

[2] Premium Finance Specialist Corp, A Division of IPFS Corporation of California (IPFS) **Eq. Customer Code:** _____