



**EQUINE INSTRUCTOR/TRAINER PROFESSIONAL LIABILITY APPLICATION
(RENEWALS)**

THIS APPLICATION IS USED TO APPLY FOR INSURANCE AND IS NOT A BINDER. EXPOSURES NOT DECLARED ARE *NOT* COVERED. All submissions must include a complete and signed application. Incomplete applications will be returned. Coverage is not bound until approved by Company Underwriting. The Company's receipt of premium does not bind coverage.

SECTION 1: APPLICANT INFORMATION

- 1.1. Applicant Name: _____ Business/LLC/Corporation Name: _____
- 1.2. Mailing Address _____ City _____ State _____ Zip Code _____
- 1.3. Physical Address _____ City _____ State _____ Zip Code _____
- 1.4. Telephone # _____ Email _____ Website _____
- 1.5. Applicant Is: ___ Corporation ___ Individual ___ Joint Venture
 ___ Limited Liability Corp (LLC) ___ Partnership ___ Sole Proprietorship

If application is a Corporation or Limited Liability Corp (LLC)

- a. Please list the names(s) of officers, partners: Their Duties:
- _____
- _____

Note: Non-Equine activities are excluded under this policy.

- 1.6. Membership/Instructor Certification: Program _____ Certificate Level _____

SECTION 2: COVERAGE INFORMATION

- 2.1. Limit of Liability – ___ Yes ___ No I wish to maintain **same limits** as expiring policy
 ___ Yes ___ No Please have someone contact me, I choose to change the **policy limits** on my renewal
- 2.2. Care, Custody and Control Limits for Non-Owned horses used in your business:
 ___ Yes ___ No I wish to maintain **same limits** as expiring policy
 ___ Yes ___ No Please have someone contact me, I choose to change my care, custody & control **policy limits**
- 2.3. Has the applicant had *any losses/claims within the past 3 years?* ___ No Losses/Claims ___ Yes Losses/Claims (If yes, on a separate page provide details of any loss (es) or claims including dates, details and amount paid within the past 3 years).

SECTION 3: PROFESSIONAL / GENERAL LIABILITY UNDERWRITING INFORMATION

(The applicant is required to keep records of the information we need for premium computation, at our discretion we may ask for copies to verify the risk information you have provided.)

- 3.1. Applicant(s) and Assistant(s) Equine Activities: (select all that apply)
 ___ Judge ___ Show Official/Manager ___ Professional Rider/Driver ___ Course Designer ___ Groom
 ___ Clinician ___ Riding Instructor ___ Steward ___ Technical Delegate
 ___ Horse Trainer (without overnight boarding) ___ Horse Trainer (with overnight boarding)
 ___ Other (describe _____)
- 3.2. Average Number of Clients/Students/Horses applicant and assistant trains/instructs per Month (be sure to include any clinic participants):
 ___ 0 -15 ___ 16 – 29 ___ 30-49 ___ 50+ (submit for rate)
- 3.3. Total Gross Annual Receipts (GAR) including Donations (the money earned over the last year, before expenses): for all equine activities listed in Section 3 Question #1 for applicant & assistant(s)
 ___ \$0-50,000 ___ \$100,001-150,000
 ___ \$50,001-\$100,000 ___ \$ _____ {Must provide actual GAR if over \$150,001 }
- 3.4. Do you use Assistants and/or Staff to help with any of your equestrian activities? ___ Yes ___ No
 If Yes, declare all Assistant/Staff information on Certificate Request Page.-See Page 5
 3.4.a. If Yes, how many? _____ Are your Assistants/Staff 16 or older? ___ Yes ___ No
- 3.5. Do you use Volunteers and/or Working Students for any of your Equine Activities? ___ Yes ___ No
 3.5.a. If Yes, how many volunteers and/or working students on average per month?
 ___ 1 -6 ___ 7-12 ___ 13-18 ___ 19-24 ___ 25+
- 3.5.b. If Yes, do volunteers or working students receive any remuneration for their services to you? If Yes, explain

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**Please Note: Injury to an employee/assistant(s), working students or volunteer(s) while acting on behalf of the applicant is excluded.*

3.6. Do you have workers compensation insurance? Yes No
[Please Note: Workers' Compensation related claims are excluded from this policy. Check with your State for the laws pertaining to Workers' Compensation Insurance requirements.]

3.7. Boarding: To have coverage for any overnight exposure to non-owned horses in your Care, Custody and Control you must complete this question:

Yes I am responsible for non-owned horses in my care **overnight**.
OR

No I am **not** responsible for non-owned horses in my care overnight.

3.7.a. If Yes, Average # of Non-Owned horses boarded monthly 1 -15 16 - 25 26-35 36-46 47-55 56+

3.7.b. If Yes, Provide Gross Annual Receipts for All Boarding \$ _____ (Note: If "none" indicate as \$0.00)

1) From boarded horses for training? \$ _____

2) From boarding contracts only (no training)? \$ _____

3) What is the Maximum value of any Non-Owned/Boarded Horse \$ _____

3.7.c. Does applicant have other insurance for boarding? Yes No

If Yes, Provide: Carrier _____ Policy # _____ Effective Date _____

3.8. Breeding Yes No

3.8.a. If Yes, is applicant responsible for non-owned horse(s) during breeding? Yes No

3.8.b. If Yes, Gross Annual Receipts for Breeding: \$ _____ (Note: If "none" indicate as \$0.00)

3.9. Does your equestrian operation ever include Trail Riding? Yes No

a. If Yes, is the cost for trail riding: Included within Lesson **OR** Hourly Rate

b. If Yes, who are Trail Rides provided to: Reoccurring Students/Clients **OR** Open to Public (i.e. Livery)

3.10. Any changes in applicants' operation in last 12 months? Yes No (If Yes, describe) _____

3.11. Does the applicant supply food, manufacture and/or repair any goods sold? Yes No

If Yes, describe _____ (Please Note: If yes, no products liability will be provided by this policy)

3.12. Do you obtain a release signed by your students, clients, boarders and volunteers relieving you of claims for bodily injury & property damage? Yes No

a. Have you made any changes in your release since last year? Yes No **If yes, a copy must accompany this application.**

MANDATORY REQUIREMENT: Equisure's receipt of such release/waiver form and subsequent possible issuance of a policy does not mean that Equisure has evaluated such release/waiver for its legalities or validity. *Note: Liability Release should release the applicant and/or the business name of the applicant from liability.*

Note: This policy does not provide coverage for any claim made or suit brought against any 'insured person' for bodily injury or 'property damage' caused by or contributed to a bite by any canine owned by, or in the care or custody of any 'insured' person.

SECTION 4: ADDITIONAL EQUINE ACTIVITIES AND LIABILITY EXPOSURES

NOTE: Coverage for selected activities requires Underwriting approval.

4.1. Additional Equine Activities (select all that apply or 'None') - Applicable supplemental questionnaire obtained from Equisure must be completed in order to receive a quote. Coverage for selected activities requires Underwriting approval.

4.1.a Pony Rides Horse Drawn Vehicle Rides Day Camps
 Horse Sales Therapeutic Other (describe _____)
 None

4.1.b **Do you wish to obtain a quote for the above activities?** Yes No
If Yes, a supplemental application is required in order to receive a quote. You can call our office for the supplemental application or you can download the supplemental application from our website: www.Equisure-inc.com, and forward along with this application.
If No, these equine activities will be excluded from coverage.

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Note: This policy does not provide coverage for the above activities until properly endorsed. The above activities will be excluded from the policy until receipt of supplemental application, underwriter approval, and receipt of additional premium.

4.2. Does applicant lease or own any ATV or Golf Carts for use in equestrian activities listed on this application? Yes No

4.2.a If Yes, do you wish to receive a quote for Liability coverage only? [Physical damage coverage is not available] Yes No

4.2.b If Yes, indicate number and type of vehicles: _____

Explain use of the vehicles: _____

Note: If purchased liability coverage only applies during the declared equine activities listed on the schedule..

NOTE: This policy does not provide coverage for any claim made or suit brought against any 'insured person' for bodily injury or property damage caused by an unlicensed operator or any operator 16 years old or younger.

If you would like information about other coverage's that might be available to you and/or your students please contact your Equisure Sales or Customer Service Agent or check the option you wish to learn more about.

- | | |
|---|---|
| <input type="checkbox"/> Farm Insurance | <input type="checkbox"/> Crime/Fidelity Coverage |
| <input type="checkbox"/> Equine Mortality/Major Medical Insurance | <input type="checkbox"/> Horse Show/Event Liability |
| <input type="checkbox"/> Directors Officers Liability | <input type="checkbox"/> Equine Personal Liability Coverage |
| <input type="checkbox"/> Cyber Liability | |

FRAUD WARNING NOTICES

STANDARD: Any person, who knowingly and with intent to defraud any insurance company or other person, files an applications 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.

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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.



Authorized Signature

Date

Print Name

By applying for this insurance, you are also applying for membership in the Association Resource Group Purchasing Group, a group formed and operating pursuant to the Liability Risk Retention Act of 1986 (15 USC 3901 et seq.) and organized in Colorado. Your membership will be effective once your completed application and membership fee have been approved and payment received.

CHECKLIST

- 1. Be sure to provide answers to ALL questions on this application.**
- 2. Sign and print your name on page 4**
- 3. Complete the certificate request form, if needed, on page 5**
- 4. Attach your release or waiver if Applicable.**
- 5. Include State Affidavit if Applicable (see below)**

**If your Physical Address is in one of the following states additional information will be required prior to policy issuance:
AR, CA, CT, DE, FL, MA, NC, NJ, NY, OH, RI, WV or WY**

~~~~~  
To cut down on our paper consumption, we now offer electronic policy delivery. Please check only one of the boxes below. (If a box is not checked, we will deliver your policy via the US Postal Service.)



- I prefer to receive my policy documents via e-mail.
- I prefer to receive my policy documents via hard copy in the mail.

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**CERTIFICATE of INSURANCE REQUEST FORM**

*This is not a binder. Please type or print clearly.*

**ALL CERTIFICATES REQUESTED BELOW WILL BE EMAILED/MAILED TO THE APPLICANT ON THIS PAGE FOR DISTRIBUTION UNLESS SPECIAL ARRANGEMENTS HAVE BEEN AGREED UPON.**

Applicant Name: \_\_\_\_\_ Email address: \_\_\_\_\_

*NOTE: Please refer to your contract in selecting the appropriate type of certificate. Include and/or attach contract if Certificate requires specific wording.*

**Certificate Holder Definitions**

- **Additional Insured's:** if added will provide insurance rights to the other party (the additional insured) if involved in a covered claim.
- **Proof of insurance:** will provide a certificate proving you have insurance but does not provide certificate holder with any coverage. **Please note we must have complete mailing addresses for either request.**

\_\_\_\_\_ **CHECK HERE IF YOU WOULD LIKE THE SAME CERTIFICATES AS EXPIRING**

|                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE HOLDER ( <i>Select One</i> ) <input type="checkbox"/> PROOF OF INSURANCE <b>OR</b> <input type="checkbox"/> ADDITIONAL INSURED (AI)<br>~~~~~<br>Check all that apply: <input type="checkbox"/> ASSISTANT/STAFF <input type="checkbox"/> LANDOWNER <input type="checkbox"/> FACILITY OWNER <input type="checkbox"/> SPONSOR <input type="checkbox"/> EQUIPMENT LESSOR |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Certificate Holder Name: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Attn: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE HOLDER ( <i>Select One</i> ) <input type="checkbox"/> PROOF OF INSURANCE <b>OR</b> <input type="checkbox"/> ADDITIONAL INSURED (AI)<br>~~~~~<br>Check all that apply: <input type="checkbox"/> ASSISTANT/STAFF <input type="checkbox"/> LANDOWNER <input type="checkbox"/> FACILITY OWNER <input type="checkbox"/> SPONSOR <input type="checkbox"/> EQUIPMENT LESSOR |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Certificate Holder Name: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Attn: \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CERTIFICATE HOLDER ( <i>Select One</i> ) <input type="checkbox"/> PROOF OF INSURANCE <b>OR</b> <input type="checkbox"/> ADDITIONAL INSURED (AI)<br>~~~~~<br>Check all that apply: <input type="checkbox"/> ASSISTANT/STAFF <input type="checkbox"/> LANDOWNER <input type="checkbox"/> FACILITY OWNER <input type="checkbox"/> SPONSOR <input type="checkbox"/> EQUIPMENT LESSOR |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Certificate Holder Name: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Attn: \_\_\_\_\_

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**\*RATING WORKSHEET FOR ANNUAL POLICY PREMIUM: Liability Limits \$1,000,000 Occurrence/\$1,000,000 Aggregate  
3.6. All other limit requests please Submit for Rate.**

**STEP 1: GROSS ANNUAL RECEIPTS (GAR) for Applicant and all Assistants (SECTION #3 – QUESTION #3)**

*[Refer to Section 3 of application to complete Steps 1 through 4]*

| Number of Horses/Students | GAR \$0-50,000 | \$50,001-\$100,000 | \$100,001-150,000 | \$150,001-\$200,000 | Over \$200,000  |
|---------------------------|----------------|--------------------|-------------------|---------------------|-----------------|
| <b>0-15</b>               | \$ 725.00      | \$ 1359.00         | \$ 1999.00        | \$ 2557.00          | Submit for Rate |
| <b>16-29</b>              | \$ 1359.00     | \$ 1559.00         | \$ 2199.00        | \$ 2849.00          | Submit for Rate |
| <b>30-49</b>              | \$ 1858.00     | \$ 1957.00         | \$ 2599.00        | \$ 3433.00          | Submit for Rate |
| <b>50+</b>                | \$ 2586.00     | \$ 2753.00         | \$ 3399.00        | \$ 4601.00          | Submit for Rate |

*(Example: 20 students, GAR \$55,000 = \$1559.00)*

**STEP 1  
GAR PREMIUM: \$ \_\_\_\_\_**

**STEP 2: ASSISTANTS/PARTNERS/STAFF**

I want coverage for Assistants/Partners (including spouse and LLC/Corporation members working in the business)

Yes                      \$325.00 x \_\_\_\_\_ # of assistants/partners

No, I do not want coverage for assistants/partners

**STEP 2  
ASSISTANT PREMIUM: \$ \_\_\_\_\_**

**STEP 3: VOLUNTEER/WORKING STUDENT PROGRAM**

I want coverage for Volunteers/Working Students

- Yes
- 1-6 per Month                      \$125.00 additional premium
  - 7-12 per Month                      \$250.00 additional premium
  - 13-18 per Month                      \$375.00 additional premium
  - 19-24 per Month                      \$500.00 additional premium
  - 25+ per Month                      Submit for Rate

No, I do not want coverage for volunteers/working students

**STEP 3  
VOLUNTEER PREMIUM: \$ \_\_\_\_\_**

**STEP 4: BOARDING (with or without income) / BREEDING:**

a. I want coverage for overnight Boarding

Yes

| 1-15 Horses OR GAR up to \$100,000 | 16-25 Horses OR GAR \$100,001 to \$150,000 | 26-35 Horses OR GAR \$150,001 to \$200,000 | 36-45 Horses OR GAR \$200,001 to \$250,000 | 46 -55 Horses OR GAR \$250,001 to \$300,000 | Over 56 Horses OR GAR over \$300,000 |
|------------------------------------|--------------------------------------------|--------------------------------------------|--------------------------------------------|---------------------------------------------|--------------------------------------|
| \$ 771.00                          | \$ 974.00                                  | \$ 1365.00                                 | \$1911.00                                  | \$2675.00                                   | Submit for Rate                      |

No, I do not want coverage for overnight boarding

**STEP 4 a  
BOARDING Premium: \$ \_\_\_\_\_**

b. I want coverage for Breeding

Yes                      \$300.00- If receipts are over \$50,000 Submit for Rate  
                                  *Professional Liability does not apply*

No, I do not want coverage for breeding

**STEP 4 b  
BREEDING Premium: \$ \_\_\_\_\_**

**STEP 5: ADDITIONAL EQUINE ACTIVITIES**

*Supplement Application Required in order to quote*

- a. Pony Rides: Submit supplemental application for Rate.  Yes  No, I do not want coverage for pony rides
- b. Day Camps: Submit supplemental application for Rate.  Yes  No, I do not want coverage for day camps
- c. Horse Sales: Submit supplemental application for Rate.  Yes  No, I do not want coverage for horse sales
- d. Other: \_\_\_\_\_: Provide details/brochure for rate.  Yes  No, I do not want coverage for other

**STEP 6: TOTAL ANNUAL POLICY PREMIUM\***

**TOTAL (Add STEPS 1 -4)                      \$ \_\_\_\_\_**

***\*NOTE: This is a premium indication ONLY based upon information provided by applicant. This worksheet does not represent all coverage combinations, changes in limits of insurance, claims history or pending claims. Policy is subject to premium audit.***

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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, made payable to Equisure, Inc., then Premium Balance Due Financed<sup>1</sup>)

\_\_\_ Credit Card (check one): \_\_\_ VISA or \_\_\_ MasterCard Amount Authorized \$ \_\_\_\_\_ We do not accept American Express or Discover

Name on Credit Card \_\_\_\_\_

Credit Card # \_\_\_\_\_

Credit Card Expiration date: \_\_\_\_\_

Signature as shown on Credit Card \_\_\_\_\_

\_\_\_ Check or Money Order (made payable to: Equisure, Inc.) \$ \_\_\_\_\_

\_\_\_ Premium Financing - Minimum 30% down payment (credit card, check or money order made payable to Equisure, Inc.) required for financing. The remaining balance, after the 30% down payment to Equisure, Inc., will be billed and paid to IPFS Corporation (IPFS)<sup>2</sup> and is not financed by Equisure, Inc. If financing a mortality policy, the minimum 30% down payment is required & Major Medical premiums must be paid in full and cannot be financed.

Premium Down Payment: \_\_\_ Credit Card \_\_\_ Check or Money Order (made payable to: Equisure, Inc.) \$ \_\_\_\_\_

\_\_\_ VISA or \_\_\_ MasterCard Amount Authorized \$ \_\_\_\_\_ We do not accept American Express or Discover

Name on Credit Card \_\_\_\_\_

Credit Card # \_\_\_\_\_

Credit Card Expiration date: \_\_\_\_\_

Signature as shown on Credit Card \_\_\_\_\_

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).



Signature \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_ Yes, I would like to receive my finance notices, finance invoices and finance statements via email from IPFS Corporation (IPFS). Please print the name and provide an email address to receive IPFS eForms. [Note: IPFS 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 \_\_\_\_\_

<sup>1</sup> Optional Endorsement and Mortality Major Medical premiums must be paid in full and cannot be financed.

<sup>2</sup> IPFS Corporation, IPFS Corporation of the South, IPFS Corporation of California (IPFS)

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