THE HARTFORD
LIVESTOCK DEPARTMENT
www.hartfordlivestock.com

ANIMAL MORTALITY APPLICATION for HORSES

(Minimum Earned Policy Premium $250.00)

THE HARTFORD

Producer's Name		Applicant's Name	
Agency Code	87 -	Mail Address	
Mail Address		City, ST Zip	
City, ST Zip		Phone	
Phone		Fax	
Fax		E-Mail Address	
E-mail Address		Policy Term Desired **(maximum term 12 months)**:	

☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Limited Liability Corp. ☐ Other _____

Proposed Effective Date: _____ ☐ New Policy
(Coverage begins on the date of acceptance by the Company) ☐ Endorsement _____ (Policy Number)

Installment Payment Plans? ☐ Yes ☐ No
(Available on Premiums over $500)

A. Animal Name	**Date of Birth**	**Date of Purchase**	**Purchase Price** (or stud fee if raised)	**Requested Limit of Insurance**

Identification (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	**Sex** (Stallion, Mare, Colt, Filly, Gelding)	**Breed**	**Use**

Primary Stable Location:

B. Animal Name	**Date of Birth**	**Date of Purchase**	**Purchase Price** (or stud fee if raised)	**Requested Limit of Insurance**

Identification (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	**Sex** (Stallion, Mare, Colt, Filly, Gelding)	**Breed**	**Use**

Primary Stable Location:

All Limits of Insurance are subject to company approval.

For a Requested Limit of Insurance that does not equal the Purchase Price, complete and attach a **Substantiation of Value**.

Type of Coverage Requested:

A	B		A	B		A	B	
☐	☐	Mortality - Full	☐	☐	Major Medical $7,500	☐	☐	Loss of Use
☐	☐	Mortality - Limited	☐	☐	Major Medical $10,000	☐	☐	Loss of Use-Limited
☐	☐	Major Medical $5,000, Basic	☐	☐	Major Medical $15,000	☐	☐	Surgical $5,000 Limit
☐	☐	Major Medical $7,500, Basic	☐	☐	Major Medical $10,000 high deductible	☐	☐	Aggregate Deductible
☐	☐		☐	☐	Accident, Sickness and Disease	☐	☐	Other _____

		Horse A Y	Horse A N	Horse B Y	Horse B N
1.	Was a pre-purchase exam completed? If Yes, a copy of the examination results may be requested by the Company.	☐	☐	☐	☐
2.	Has the horse been examined or treated by a veterinarian for any accident, injury, sickness, disease, lameness, or other than routine care within the last year?	☐	☐	☐	☐
3.	Is the horse currently free of lameness and healthy without the use of drugs?	☐	☐	☐	☐
4.	Has the horse undergone diagnostic ultrasound, bone scan, or x-rays within the last 36 months?	☐	☐	☐	☐
5.	Does the horse have any past conformational problems or defects, illness or disease, lameness, or injury or physical disability including, but not limited to: laminitis/founder, OCD, neurological disorders (e.g. EPM) navicular disease, and/or degenerative joint disease?	☐	☐	☐	☐
6.	Has the horse been nerved or received any treatment for lameness?	☐	☐	☐	☐
7.	Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 36 months?	☐	☐	☐	☐
8.	Has the horse had any colic, colic surgery, impaction, or intestinal disorder within the last 36 months?	☐	☐	☐	☐
9.	Is the horse due to foal any time during the requested Policy Period? If Yes, please give: Estimated Foaling Date: _____; Number of Previous Foals: _____; Stud fee: _____	☐	☐	☐	☐
10.	Has the horse ever experienced birthing difficulties? (Mares only)	☐	☐	☐	☐
11.	Does the horse have an ancestor known to carry HYPP? If No, please move on to question **12**.	☐	☐	☐	☐
	a. Has the horse been HYPP tested? If Yes, please check the test results.	☐	☐	☐	☐
	N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B				
	b. Please check the HYPP test results of the horse's Sire and Dam.				
	Sire: N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B Unknown ☐A ☐B				
	Dam: N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B Unknown ☐A ☐B				
	c. Has the horse ever shown any HYPP signs or symptoms?	☐	☐	☐	☐

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12. Will the horses be observed and cared for daily? ☐Yes ☐No If No, explain:

13. Who was each horse acquired from?

14. Are you the sole owner of the horses? ☐Yes ☐No If No, provide other owner's % of interest, name and address:

15. Loss Payee(s): _____
(Name and Address)

16. If the Purchase Price was not paid entirely in cash, please describe the transaction in detail.

17. Are the horses leased to others? ☐Yes ☐No If Yes, please attach a copy of the lease(s).

18. Is there any other insurance on the horses? ☐Yes ☐No If Yes, provide the carrier name: _____
Expiration date: _____ Amount of coverage: _____

19. Has any insurance carrier ever canceled, non-renewed or refused to insure any horse in which you have or had an insurable interest? ☐Yes ☐No If Yes, provide details: (Not applicable in MO) _____

20. Have you lost any horse in the last 5 years (whether or not insured) or have any medical/surgical or colic claims been filed on the above listed horse? ☐Yes ☐No
If Yes, give date, cause, value and explain:

21. Name, address, and telephone number of the horse's primary licensed Veterinarian:

22. Do you understand that the insurance policy you are applying for requires you to give the Company immediate notice of any covered animal's death, injury, sickness, or disease, along with a description of the condition and the name of the attending veterinarian? Do you also understand that failure to give this immediate notice may result in the denial of a claim? ☐Yes ☐No

Please provide details for any **"Yes"** answers to questions 2,4,5,6,7,8,10 and 11c. and any **"No"** answers to questions 3 and 22.

Note: A Veterinarian Certificate of Exam is required if:

1. **Horse is under 6 months of age**
2. **Horse is over 16 years of age**
3. **Horse is valued over $50,000**
4. **You have not known the horse over 30 days**
   (A pre-purchase exam no older than 30 days can be submitted in place of the vet exam)

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☐ COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT.
(Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU INCONNECTION WITH THIS APPLICATION FOR INSURANCE. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY USOR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEWYOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS ANDOUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMITA REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE ORSTATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANYFACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVILPENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDINGTHE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS, IFFALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR ANAPPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE ORBELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF,OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR ACLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TOCONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATIONCONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY ORANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FORTHE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BEA CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OFDEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THEANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HERKNOWLEDGE.

APPLICANTS SIGNATURE 	DATE (Must be no more than 30 days prior to policy effective date)

PRODUCERS SIGNATURE	PRODUCERS NAME(Please Print)	STATE PRODUCER LICENSE NO. (Required in Florida)

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VETERINARIAN'S STATEMENT OF EXAMINATION

For Horses

THE HARTFORD

Producer's Name		Applicant's Name	
Agency Code		Mail Address	
Mail Address		City, ST Zip	
City, ST Zip		Phone	
Phone		Fax	
Fax		E-Mail Address	
E-mail Address			

Horse Name: **Date of Birth:** **Sex:** **Use:**

For Quarter Horses, Appaloosas, or Paints that have an ancestor known to carry HYPP, please indicate the horse's HYPP status *(check one.)* ☐**N/N** ☐**N/H** ☐**H/H** ☐**N/A**

Has the horse experienced any HYPP signs or symptoms?. ☐Yes ☐No If Yes, please explain:

Pulse and Respiration normal at rest and after work? ..... ☐ Yes ☐ No
Heart auscultation normal at rest and after work? ..... ☐ Yes ☐ No
Respiration auscultation normal at rest and after work? ..... ☐ Yes ☐ No
Temperature normal? ..... ☐ Yes ☐ No
Eyes clinically normal? ..... ☐ Yes ☐ No
Palpitations normal?
- Back ..... ☐ Yes ☐ No
- Stifles ..... ☐ Yes ☐ No
- Knees ..... ☐ Yes ☐ No
- Hocks ..... ☐ Yes ☐ No
- Fetlocks ..... ☐ Yes ☐ No
- Tendons and Ligaments ..... ☐ Yes ☐ No

(Please note any swelling, heat, stiffness and/or pain for any answer "No".)

Hoof tester results negative? ..... ☐ Yes ☐ No
Properly shod? ..... ☐ Yes ☐ No
Is the stabling and turn out safe and adequate? ..... ☐ Yes ☐ No

If any are answered no, please explain on a separate page

Are you the usual veterinarian for the applicant? ..... ☐ Yes ☐ No
If no, have you treated/examined this horse previously? Explain:

Has the horse ever had colic surgery? ..... ☐ Yes ☐ No
Subject to or any previous history of colic? ..... ☐ Yes ☐ No
History or evidence of a bleeder? ..... ☐ Yes ☐ No
History or evidence of nerving? ..... ☐ Yes ☐ No
Any evidence or history of laminitis, club foot, or P3 rotation? .... ☐ Yes ☐ No
Any evidence of infection or disease? ..... ☐ Yes ☐ No
Contagious diseases on premises or locally? ..... ☐ Yes ☐ No
Is there evidence of objectionable habits? Vices? ..... ☐ Yes ☐ No
Any history of uncharacteristic behavior in the last 24 months? ..... ☐ Yes ☐ No
Any major conformation faults, which may affect the horse for its intended use, short or long term? ..... ☐ Yes ☐ No
Any evidence of lameness jogging straight or on circles in both directions? ..... ☐ Yes ☐ No
Any evidence of bone or joint disease? ..... ☐ Yes ☐ No
Is the horse subject to chronic metritis and/or mastitis? ..... ☐ Yes ☐ No
Is the horse pregnant? ..... ☐ Yes ☐ No
If Yes, give expected date of birth: _____
If the horse is a breeding horse, to your knowledge is there any history of gestation, lactation or parturition problems? . ☐ Yes ☐ No

If any are answered yes, please explain on a separate page.

Are you aware if the horse has received any performance enhancing procedures, including intramuscular and/or joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? ..... ☐ Yes ☐ No
Have you or any other veterinarians attended the horse for any ailment, injury, lameness, or medical problem in the last 12 months? ..... ☐ Yes ☐ No
Has the horse ever undergone surgery? ..... ☐ Yes ☐ No
Are you aware of any condition, past or present that could require surgical or medical attention in the next 12 months? ..... ☐ Yes ☐ No
Are you aware of any history of unsoundness, injury or disease on this horse? ..... ☐ Yes ☐ No
Other findings or remarks? _____
Provide details of any degenerative changes, bone spurs, chips or osteochondrosis seen on any radiographs taken.

If any are answered yes, please explain on a separate page.

If Loss of Use Coverage is being requested, please complete the following:

X-rays: Must be current within 30 days. Please list below all radiographic findings, especially those that may affect the horse's long term and short-term intended use. If possible, use any previous X-rays for comparisons, i.e. navicular. All views listed below are required for Full Loss of Use coverage. If additional views were taken, please describe results. Use a separate page if necessary. **Note NSF and WNL are not acceptable descriptions for findings.**

Front Feet - Lateromedial, dorsal ventral, navicular skyline:

Front Fetlocks - A/P views:

Hind Fetlocks – A/P views:

Hocks – Lateral projection, craniocaudal projection, both oblique:

Stifles – Lateromedial views:

Give your general evaluation for the above named horse, and your professional opinion on soundness, both short and long term, for its intended use.

_____ Veterinarian's Signature

_____ Date

_____ Telephone Number

Veterinarian's Address: _____

_____

_____

THE HARTFORD
LIVESTOCK DEPARTMENT
(800)-295-1815
www.hartfordlivestock.com

Substantiation of Value
Horses

THE HARTFORD

This document forms part of the Animal Mortality Application

Applicant's Name		Policy Number:	
Mail Address		Animal Name:	
City, ST Zip		Purchase Price:	$
Phone		Purchase Date:	
Fax		Amount of	
E-Mail Address		Insurance Desired:	$

Breed _____ Use _____ Sex _____ Date of Birth _____
Sire: _____ Dam: _____ Registration Number _____

Show / Performance Record(s)

Show / Competition	Show Rating **N**=National **D**=District **R**=Regional **C**=County **S**=State **L**=Local	Date of Show	Class / Division	Number of Entries	Placement	Winnings	Number of Points
						$	
						$	
						$	
						$	

Training Record(s)

Name of Trainer	Type of Training	Cost of Training (Excluding Board, Vet and Maintenance Fees)		
		Per Month	Number of Months	Total Cost
				$
				$

Breeding Stallions

Number of Non-Owned Mares Booked This Year	Number of Non-Owned Mares Bred This Year	Stud Fee Charged	This Years Annual Breeding Income*

Number of Non-Owned Mares Booked Last Year	Number of Non-Owned Mares Bred Last Year	Stud Fee Charged	Last Years Annual Breeding Income*

*Breeding Income is defined as the amount of money that was earned in that particular year when stud fees were paid to you after the fulfillment of breeding contracts.
Any Additional information _____

Broodmare Record

Number of Live Births Since Owned	Number of Foals		Average Selling Price of		Is Mare Pregnant now? Yes or No (If Yes, Amount of Stud/Service Fee)	Due Date
	Sold Since Owned	Average Selling Price	Full Siblings	Half Siblings		
		$	$	$	☐Yes ☐No $	

Foal Record

Stud Fee of Sire	Average Selling Price of Full Siblings	Average Selling Price of Half Siblings
$	$	$

Other Information to Substantiate Value:

Applicant declares the above statements are true and complete, and that no material information was withheld.

Applicants Signature	Date:
SIGN HERE	

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PAYMENT OPTIONS FORM

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

INSURANCE (*select*) ___ **Liability** ___ **Mortality**

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[1])**

___ **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)[2] 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).*

SIGN HERE

_____ _____

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

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

[2] IPFS Corporation, IPFS Corporation of the South, IPFS Corporation of California (IPFS)