



## APPLICATION for *Equine Mortality Insurance*

\_\_\_ NEW \_\_\_ RENEWAL \_\_\_ ADD TO CURRENT POLICY

DESIRED EFFECTIVE DATE \_\_\_\_\_

Applicant's Name: (Owner or Lessee) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Business: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_ FAX Number: \_\_\_\_\_

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

### Step 1: HORSE INFORMATION

Horse	Name & Registration/Tattoo #	Age or Birthdate	Sex	Breed	Use	Purchase Date	Purchase Price or Stud Fee	Insured Value
A								

SIRE \_\_\_\_\_ DAM \_\_\_\_\_

B								
---	--	--	--	--	--	--	--	--

SIRE \_\_\_\_\_ DAM \_\_\_\_\_

C								
---	--	--	--	--	--	--	--	--

SIRE \_\_\_\_\_ DAM \_\_\_\_\_

### Step 2: OPTIONAL COVERAGE

- **Select Major Medical *OR* Surgical coverage. The maximum payable amount is either the agreed horse value or limits selected below, whichever is less.**

#### Horse A

\_\_\_ Major Medical

- |  |                |                        |         |        |
|--|----------------|------------------------|---------|--------|
| <ul style="list-style-type: none"> <li>• \$7,500 limit, \$450 deductible</li> </ul>  | With co-pay    | Annual Premium = \$525 | ___ Yes | ___ No |
|  | Without co-pay | Annual Premium = \$700 | ___ Yes | ___ No |
| <ul style="list-style-type: none"> <li>• \$10,000 limit, \$550 deductible</li> </ul> | With co-pay    | Annual Premium = \$575 | ___ Yes | ___ No |
|  | Without co-pay | Annual Premium = \$750 | ___ Yes | ___ No |
| <ul style="list-style-type: none"> <li>• \$15,000 limit, \$675 deductible</li> </ul> | With co-pay    | Annual Premium = \$750 | ___ Yes | ___ No |
|  | Without co-pay | Annual Premium = \$950 | ___ Yes | ___ No |

**OR**

\_\_\_ Surgical, \$5,000 limit or the sum insured of the horse, whichever is less

- |   |                        |         |        |
|---|------------------------|---------|--------|
| • Surgical, deductible applies            | Annual Premium = \$200 | ___ Yes | ___ No |
| • Race Horse Surgical, deductible applies | Annual Premium = \$275 | ___ Yes | ___ No |

<b>Horse B</b>			
<input type="checkbox"/> Major Medical			
• \$7,500 limit, \$450 deductible	With co-pay	Annual Premium = \$525	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$700	<input type="checkbox"/> Yes <input type="checkbox"/> No
• \$10,000 limit, \$550 deductible	With co-pay	Annual Premium = \$575	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$750	<input type="checkbox"/> Yes <input type="checkbox"/> No
• \$15,000 limit, \$675 deductible	With co-pay	Annual Premium = \$750	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$950	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>OR</b>			
<input type="checkbox"/> Surgical, \$5,000 limit or the sum insured of the horse, whichever is less			
• Surgical, deductible applies		Annual Premium = \$200	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Race Horse Surgical, deductible applies		Annual Premium = \$275	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Horse C</b>			
<input type="checkbox"/> Major Medical			
• \$7,500 limit, \$450 deductible	With co-pay	Annual Premium = \$525	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$700	<input type="checkbox"/> Yes <input type="checkbox"/> No
• \$10,000 limit, \$550 deductible	With co-pay	Annual Premium = \$575	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$750	<input type="checkbox"/> Yes <input type="checkbox"/> No
• \$15,000 limit, \$675 deductible	With co-pay	Annual Premium = \$750	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Without co-pay	Annual Premium = \$950	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>OR</b>			
<input type="checkbox"/> Surgical, \$5,000 limit or the sum insured of the horse, whichever is less			
• Surgical, deductible applies		Annual Premium = \$200	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Race Horse Surgical, deductible applies		Annual Premium = \$275	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Step 3: QUESTIONNAIRE

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

3.1. Are you the sole owner of the horse(s)?  Yes  No If no, list owners and addresses or lienholders/banks and addresses \_\_\_\_\_

3.2. Usual location of horse(s), provide address and phone number \_\_\_\_\_  
\_\_\_\_\_

3.3. Name, address and telephone number of your usual veterinarian  
\_\_\_\_\_

3.4. Is horse(s) on vaccination and worming program approved by a vet?  Yes  No If yes, provide frequency \_\_\_\_\_

3.4.a Has horse been vaccinated against West Nile Virus  Yes  No

- 3.5. Is there now any contagious or infectious disease on the premises, or has there been during the past 12 months?  
 Yes  No If yes, please explain \_\_\_\_\_
- 3.6. For all Quarter Horses, Appaloosas or Paint horses, does any horse(s) have an ancestor know to carry HYPP?  
 Yes  No If yes, indicate the status for each horse (N/N, N/H, H/H) NOTE: H/H horses are not insurable.  
 \_\_\_\_\_
- 3.7. Are horse(s) presently insured?  Yes  No Previously insured?  Yes  No If yes, to either question give name of company, date and amount \_\_\_\_\_
- 3.8. Has any company cancelled or refused to renew your coverage?  Yes  No If yes, please provide reason \_\_\_\_\_
- 3.9. Has any horse(s) owned by you died within the past 24 months (whether or not insured)?  Yes  No If yes, state number of deaths and causes of death \_\_\_\_\_  
 \_\_\_\_\_

#### Step 4: DECLARATION OF HEALTH

**At inception of the policy, all animals must be sound, healthy and have no known injury, lameness or disease. Any pre-existing conditions are not covered, unless otherwise noted and agreed to by the Company.**

- 4.1. Does the horse(s) have any history of injury, illness, lameness or disease (including melanomas, sarcoids, warts or other types of growth)?  Yes  No If yes, provide details including date \_\_\_\_\_  
 \_\_\_\_\_
- 4.1.a Does the horse(s) have any conformation issues that could affect its ability to be used for the intended use?  Yes  No If yes, provide details \_\_\_\_\_
- 4.1.b Any laminitis/founder, OCD, navicular disease, degenerative joint disease and/or neurologic disorders?  
 Yes  No If yes, provide details \_\_\_\_\_
- 4.2. Has the horse(s) had any veterinary treatment including acupuncture or chiropractic (other than routine preventative vaccinations) or are they unsound in any way?  Yes  No If yes, provide details \_\_\_\_\_  
 \_\_\_\_\_
- 4.2.a Does the horse receive any medications/supplements?  Yes  No If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_
- 4.3. Has any horse(s) suffered from colic or any other gastro-intestinal related illness?  Yes  No If yes, provide details including dates \_\_\_\_\_
- 4.4. Has any horse(s) been examined or treated by a veterinarian for other than routine care?  Yes  No If yes, provide details including dates \_\_\_\_\_
- 4.5. Has any horse(s) undergone surgery (other than castration), been fired, blistered or nerved?  Yes  No  
 If yes, provide details including dates and results \_\_\_\_\_
- 4.5.a Has the horse(s) undergone diagnostic ultrasound, x-rays, or bone scans within the last 24 months?  
 Yes  No If yes, provide details including dates and results \_\_\_\_\_  
 \_\_\_\_\_

4.6. Are there any other facts within your knowledge not already disclosed affecting or likely to affect the Company's acceptance of the proposed risk? \_\_\_ Yes \_\_\_ No If yes, please explain \_\_\_\_\_

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 persons to criminal and civil penalties.

I declare to the best of my knowledge and belief that the horse(s) listed on the above application to be in normal healthy sound condition. I hereby certify that the above information is truthful and accurate. I understand that any fraudulent, omitted or misrepresented statement voids any policy of insurance issued on the basis of this application. I further understand that the insurer will rely on the information provided in this application, which will become part of any policy issued.

I understand and agree this is not a binder, but merely an application for insurance. I also understand that it is required under the policy to give immediate notice by telephone of any illness, injury, disease or death of any insured horse. Not doing so may jeopardize coverage and result in denial of any claim made.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

-----  
**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**

- Please note that additional premium applies for ALL optional coverages in step 2.
- Major Medical not available on horses under 90 days or over 18 years of age.
- \$250.00 Minimum Premium applies if this policy is cancelled prior to the expiration date.

#### Checklist

- \_\_\_\_\_ I completed Step 1 for all horses I wish to insure for Mortality/Theft or Major Medical.
- \_\_\_\_\_ I completed Step 2 because I wish to purchase Major Medical Insurance **in addition** to Mortality and Theft.
- \_\_\_\_\_ I completed all the questions in Step 3
- \_\_\_\_\_ I completed all the questions in Step 4
- \_\_\_\_\_ I signed and dated above and acknowledge the agreement
- \_\_\_\_\_ Complete **page 5 OR 6 ONLY** if you wish to insure your horse for more than the purchase price
- \_\_\_\_\_ Read and complete page 7
- \_\_\_\_\_ FINALLY, make payment on page 8



## 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** (certificates, breeds and disciplines, other related education):

---

---

---

---

**Familiarity with Horse** (how long have you 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**



**SHOW RECORDS FORM**

**Use for 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)

Eq. Code \_\_\_\_\_

Edition 8/2017



## 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](http://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, 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)