

**ANIMAL MORTALITY APPLICATION
for HORSES**



(Minimum Earned Policy Premium \$250.00)

Producer's Name _____ Agency Code <u>87 -</u> Mail Address _____ City, ST Zip _____ Phone _____ Fax _____ E-mail Address _____	Applicant's Name _____ Client Code: _____ Mail Address _____ City, ST Zip _____ Phone _____ Fax _____ E-Mail Address _____ Policy Term Desired (maximum term 12 months): _____
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Individual
 Partnership
 Corporation
 Joint Venture
 Limited Liability Corp.
 Other _____

Proposed Effective Date: _____ New Policy
 Installment Payment Plans? Yes No
 (Coverage begins on the date of acceptance by the Company)
 Endorsement _____ (Policy Number)
 (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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mortality - Full		Major Medical \$7,500		Loss of Use	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Mortality - Limited		Major Medical \$10,000		Loss of Use-Limited	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Major Medical \$5,000, Basic		Major Medical \$15,000		Surgical \$5,000 Limit	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Major Medical \$7,500, Basic		Major Medical \$10,000 high deductible		Aggregate Deductible	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>		Accident, Sickness and Disease		Other _____	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

	Horse A		Horse B	
	Y	N	Y	N
1. Was a pre-purchase exam completed? If Yes, a copy of the examination results may be requested by the Company.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the horse currently free of lameness and healthy without the use of drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the horse undergone diagnostic ultrasound, bone scan, or x-rays within the last 36 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the horse been nerved or received any treatment for lameness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the horse had any colic, colic surgery, impaction, or intestinal disorder within the last 36 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the horse ever experienced birthing difficulties? (Mares only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does the horse have an ancestor known to carry HYPP? If No, please move on to question 12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Has the horse been HYPP tested? If Yes, please check the test results. N/N <input type="checkbox"/> A <input type="checkbox"/> B N/H <input type="checkbox"/> A <input type="checkbox"/> B H/H <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Please check the HYPP test results of the horse's Sire and Dam. Sire: N/N <input type="checkbox"/> A <input type="checkbox"/> B N/H <input type="checkbox"/> A <input type="checkbox"/> B H/H <input type="checkbox"/> A <input type="checkbox"/> B Unknown <input type="checkbox"/> A <input type="checkbox"/> B Dam: N/N <input type="checkbox"/> A <input type="checkbox"/> B N/H <input type="checkbox"/> A <input type="checkbox"/> B H/H <input type="checkbox"/> A <input type="checkbox"/> B Unknown <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Has the horse ever shown any HYPP signs or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (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 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.

IN FLORIDA, 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.

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF 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 A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING 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 OR ANOTHER 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 COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A 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 OF DEFRAUDING 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 THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

APPLICANTS SIGNATURE

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

 SIGN HERE

PRODUCERS SIGNATURE

PRODUCERS NAME (Please Print)

STATE PRODUCER LICENSE NO.
(Required in Florida)

**Substantiation of Value
Horses**



This document forms part of the Animal Mortality Application

Applicant's Name _____	Client Code: _____	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		Date of Show	Class / Division	Number of Entries	Placement	Winnings	Number of Points
	N=National R=Regional S=State	D=District C=County L=Local						
							\$	
							\$	
							\$	
							\$	

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		
		\$	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____
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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* _____ Client Code: _____

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 Financed¹)

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.*)



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)