EQUINE INSTRUCTOR/TRAINER PROFESSIONAL LIABILITY

EQUINE ASSISTED ACTIVITIES AND THERAPY (EAAT) - Renewal

PROUD SPONSORS OF CHA PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

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

CLIENT CODE:_____

1.1. Applicant Name:_____

1.2. Business/LLC/Corporation Name: _____

I am applying for insurance: ___ **I am the authorized representative for the business/facility listed above**

___ **I am the instructor**

1.3. Mailing Address_____**City**_____ **State**_____**Zip Code** _____

1.4. Physical Address_____**City**_____ **State**_____**Zip Code** _____

1.5. Telephone # _____ **Email** _____ **Website**_____

1.6. Applicant is: ____ **Corporation** ____ **Individual** ____ **Joint Venture**

____ **Limited Liability Corp (LLC)** ____ **Partnership** ____ **Sole Proprietorship**

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

Name of officers, partners	Active in Equestrian Activities	Their Duties:
_____	___ Yes ___ No	_____
_____	___ Yes ___ No	_____

Note: Non-Equine activities are excluded under this policy

1.7. Please list all EAAT Riding/Instruction Association(s) or Groups you are affiliated/accredited with?

_____

Certification: Program_____**Certificate/Certification Level** _____

(CHA and PATH members must attach a valid membership card)

1.8. Are you over the age of 18? ___ Yes ___ No

1.9. Is this a non-profit group? ___ Yes ___ No

1.10. Do you have Directors and Officers Liability insurance for this group? ___ Yes ___ No

1.11. Do you offer instruction all year? ___ Yes ___ No If no, please provide the dates of your program_____

SECTION 2: COVERAGE AND LIMITS OF INSURANCE

2.1. Limit of Liability – Select One Option: ___ I wish to maintain **same limits** as expiring policy

___ 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:

___ I wish to maintain **same limits** as expiring policy

___ Please have someone contact me, I choose to **change** the **policy limits** on my renewal

SECTION 3: PROFESSIONAL / GENERAL LIABILITY UNDERWRITING INFORMATION

3.1. Please indicate Yes for all equestrian activities that apply to the applicant individual/business (s) or facility applying for insurance coverage, or No:

_____ Judge	_____ Professional Rider/Driver	_____ Clinician
_____ Show Official/Manager	_____ Course Designer	_____ Groom
_____ Riding Instructor	_____ Steward	_____ Technical Delegate
_____ Horse Trainer Horse Trainer (without overnight boarding)		_____ Horse Trainer (with overnight boarding)
_____ Other (describe _____)		

3.2. If yes to clinician in 3.1, how many clinic days per year? _____

3.3. Total Monthly Number of Clients + Students/Participants + Horses (in training) for applicant and any assistant's trainers/instructors (a student having weekly lessons only counts once per month):

___ **0– 15** ___ **16 – 29** ___ **30 – 49** ___ **50-100** ___ **100+ (***Submit for Rate)*

3.4. Tell us about your program by providing a percentage of your operation for each activity, it must total 100%

3.4.a. Equine Facilitated Therapy including Psychotherapy and Hippotherapy _____%
(Equine Assisted/Facilitated Psychotherapy, PT, OT, SLP)
Mark the activities with an "x" that apply for this Service:
___Mounted Riding ___Driving ___Vaulting ___Ground

3.4.b. Equine Facilitated Learning _____%
Mark the activities with an "x" that apply for this Service:
___Mounted Riding ___Driving ___Vaulting ___Ground

3.4.c. Therapeutic Services Including Developing Equestrian Skills _____%
Mark the activities with an "x" that apply for this Service:
___Mounted Riding ___Driving ___Vaulting ___Ground

3.4.d. Other therapeutic : Give details_____ _____%
Mark the activities with an "x" that apply for this Service:
___Mounted Riding ___Driving ___Vaulting ___Ground

Percentage from above must total = 100%

3.5. Total Gross Annual Receipts (GAR) including Donations (before expenses) for all equestrian exposures, including EAAT Activities and Traditional Instruction/Training listed in question #1 above. Please exclude boarding receipts & anything not listed in 3.1.

___ $0,$50,000 ___ $50,001-$100,000 ___ $100,001-$150,000
___ $150,001-$200,000 ___ $200,001+ _____ {Must provide actual GAR if over $200,001}

3.6. The equine activities declared on this application are provided by:

_____ Applicant Only _____ Assistants (employees) _____ Other: Explain_____

3.7. Do you use Assistants and/or Staff to help with any of your equestrian activities? ___ Yes ___ No ___
3.7.a. If Yes, how many? _____ Are your Assistants/Staff 16 or older? ___ **Yes** ___ **No**
3.7.b. If Yes, list names and addresses below

_____

_____

3.8. Do you use Volunteers and/or Working Students for any of your Equine Activities? ___ Yes ___ No
IF Yes, how many volunteers and/or working students on average per month?
___ 1-6 ___ 7-12 ___ 13-18 ___ 19-24 ___ 25-50 ___ 50+

3.9. Do volunteers or working students receive any remuneration for their services to you? ___Yes ___ No If yes, explain
_____

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

3.10. 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.]

3.11. Is proper safety equipment required for use by all participants? ___ Yes ___ No

3.12. Are you or any of your assistants/staff/contractors licensed/certified mental health care professional(s) or licensed clinical professionals? ___ Yes ___ No (If *yes, please provide a copy of your professional/malpractice liability declaration insurance page covering this work. Must provide a copy.*)
Note: No coverage is provided under the policy to which you are applying, for the professional/malpractice liability of licensed clinical work.

Note: No coverage is provided under the policy to which you are applying, for the transportation of participants or volunteers. No auto liability is provided by this policy.

3.13. Boarding: ___ **Yes,** I am responsible for non-owned horses in my care **overnight.** .
___ **No,** I am **not** responsible for non-owned horses in my care **overnight**.

3.13.a. If Yes, Average # of Non-owned horses boarded monthly: ___ 1 -15 ___ 16 – 25 ___ 26-35 ___ 36-45 ___ 46-55 ___ 56-99 ___ 100+

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

3.13.c. Are you responsible for non-owned horses overnight at shows? ___ Yes ___ No If yes, # of non-owned horses. _____

3.13.d. What is the Maximum value of any Non-Owned Horse $ _____

3.13.e. Does applicant have other insurance for boarding? ___ Yes ___ No

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

3.13.f. Do you wish to include boarding coverage on this policy? ___ Yes ___ No

3.14. Breeding ___ Yes ___ No

3.14.a. Is applicant responsible for non-owned horse(s) during breeding? ___ Yes ___ No

3.14.b. Gross Annual Receipts for Breeding: $ _____ *(Note: If "none" indicate as $0.00)*

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

3.16. 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)*

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

3.17.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 (*indicate Yes for all that apply or No*) - Applicable *supplemental questionnaire obtained from Equisure must be completed in order to receive a quote. Coverage for selected activities requires Underwriting approval.*

_____ Pony Rides _____ Horse Drawn Vehicle Rides
_____ Day Camps _____ Horse Sales
_____ Trail Riding to regular weekly or monthly students (includes arena instruction)
_____ Trail Riding to client impromptu or scheduled not your regular student (short lesson or video)
_____ Other (describe) _____

Do you wish to obtain a quote for the above activities? ___ Yes ___ No (If Yes, a supplemental application is required, or you can download the supplemental application(s) from our website: www.equisure-inc.com, and forward along with this application. If No, these equine activities will be excluded from coverage.)

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/own any ATV, Golf Cart or other off-road (non-licensed) vehicles for use in equestrian activities listed on this application? ___ Yes ___ No

If Yes, do you wish to receive a quote for Liability coverage only? *[Physical damage is not available]* **___ Yes ___No**

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.

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.

SECTION 5: INSURANCE HISTORY

5.1. Has the applicant had any losses/claims within the past 3 years? ___ Yes Losses/Claims ___ No 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 6: PERSONAL EQUINE LIABILITY OPTION

____ YES ____ NO

This is an optional endorsement to the business policy, designed to protect you against claims arising out of bodily injury or property damage caused by your horse during **personal** use (trail riding, showing, pasturing). For owners with 4 or less horses.

Declared Private Owned Horses (OWNED or LEASED 100% BY THE APPLICANT)

Application must be submitted for a rate if you own/lease more than four horses.

HORSE NAME	SEX	USE	AGE	REGISTRATION/ COLOR/MARKINGS	BREED

CHANGES MADE TO THE DECLARED OWNED/LEASED HORSES DURING THE POLICY TERM NEED TO BE MADE IN WRITING.

DISCLAIMERS

I. 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.

II. 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.

TERMS AND CONDITIONS

I acknowledge that this application is applicable to **Equine Assisted Activities Therapy Liability only**. I understand that no other coverage is included and that any additional coverage must be purchased separately. I acknowledge that I have read and agree to the following Terms and Conditions.

I. All quotes provided are good faith estimates only and are based on information provided to us by the customer, and by the insurance companies quoting. All quotes are subject to underwriting rules and requirements, such as loss history. Various cancellation penalties and minimum earned premiums may apply.

II. The insured expressly grants the agency the authority to cancel any or all policies in order to recover monies due because of non-payment of premium on any policy.

III. It is imperative that all claims be reported promptly to the agency or the insurance company in writing.

IV. The agency endeavors to explain coverages and available options but makes no claim or warranty that all possible coverages or options have been offered. It is the buyer's sole responsibility to judge the suitability of the insurance program for their purposes and to understand the limits, perils insured against, exclusions, and limitations of the policies they buy.

V. All coverages are afforded by a written binder or by a company issued policy. No coverage is in force until written confirmation is received from the agency or the insurance company. All additions, deletions, or other changes must be issued by the insurance company to be valid.

VI. The insurance policy is the contract between you and the insurance company. Read your policy and bring to your agent's attention any aspect that you do not understand, or any desired changes to limits or coverages.

VII. Some policies have territorial limits of which you should make yourself aware if you do business or have business travel outside the territorial limits of the United States.

VIII. Acceptance of this application by signature and by payment of premium constitutes acceptance of, understanding of, and agreement to these terms and conditions.

EQUINE INSTRUCTOR/TRAINER PROFESSIONAL LIABILITY

EQUINE ASSISTED ACTIVITIES AND THERAPY (EAAT) - Renewal

PROUD SPONSORS OF CHA PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

I would like information about the following available coverages.

___ Yes ___ No Club Liability ___ Yes ___ No Crime ___ Yes ___ No Cyber Liability

___ Yes ___ No Directors & Officers Liability ___ Yes ___ No Personal Equine Liability ___ Yes ___ No Animal Mortality

___ Yes ___ No Special Event Liability ___ Yes ___ No Other (describe)_____

To cut down on our paper consumption, we now offer electronic policy delivery. Please select one of the options below.

___ - I prefer to receive my policy documents via e-mail.

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

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.

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.

SIGN HERE

_____ _____

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 complete ALL questions of this application.**
2. **Sign and print your name above**
3. **Complete the certificate request form, if needed, on page 7**
4. **Attach your release or waiver if changed.**
5. **Include State Affidavit if Applicable**

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

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 *(SELECT ONE)* ___ **PROOF OF INSURANCE OR** ___ **ADDITIONAL INSURED (AI)**
CHECK ALL THAT APPLY
___ **ASSISTANT** ___ **LANDOWNER** ___ **FACILITY OWNER** ___ **SPONSOR** ___ **EQUIPMENT LESSOR**

CERTIFICATE HOLDER NAME:_____
MAILING ADDRESS: _____
CITY/STATE/ZIP: _____
ATTN: _____

CERTIFICATE HOLDER *(SELECT ONE)* ___ **PROOF OF INSURANCE OR** ___ **ADDITIONAL INSURED (AI)**
CHECK ALL THAT APPLY
___ **ASSISTANT** ___ **LANDOWNER** ___ **FACILITY OWNER** ___ **SPONSOR** ___ **EQUIPMENT LESSOR**

CERTIFICATE HOLDER NAME:_____
MAILING ADDRESS: _____
CITY/STATE/ZIP: _____
ATTN: _____

CERTIFICATE HOLDER *(SELECT ONE)* ___ **PROOF OF INSURANCE OR** ___ **ADDITIONAL INSURED (AI)**
CHECK ALL THAT APPLY
___ **ASSISTANT** ___ **LANDOWNER** ___ **FACILITY OWNER** ___ **SPONSOR** ___ **EQUIPMENT LESSOR**

CERTIFICATE HOLDER NAME:_____
MAILING ADDRESS: _____
CITY/STATE/ZIP: _____
ATTN: _____
~~~~~~

EQUINE INSTRUCTOR/TRAINER PROFESSIONAL LIABILITY

EQUINE ASSISTED ACTIVITIES AND THERAPY (EAAT) - Renewal

PROUD SPONSORS OF CHA PATH INTERNATIONAL Professional Association of Therapeutic Horsemanship International

***RATING WORKSHEET FOR ANNUAL POLICY PREMIUM: Liability Limits $1,000,000 Occurrence/$1,000,000 aggregate.**

- **All other limit requests please Submit for Rate**

STEP 1: TOTAL INCOME (*BEFORE EXPENSES*) Refer to Section 3

Number of Horses/Students	GAR $0-50,000	$50,001-$100,000	$100,001-150,000
0-15	$ 1049.00	$ 1668.00	$ 2308.00
16-29	$ 1668.00	$ 1916.00	$ 2508.00
30-49	$ 2167.00	$ 2266.00	$ 2908.00
50-100	$ 2895.00	$ 3062.00	$ 3448.00

Horses over 100 or GAR over $150,000 SUBMIT FOR RATE

(*Example: 20 students, Total Income $55,000 = $1916.00)*

STEP 1 INCOME Premium: $_____

STEP 2: CLINICS

I want coverage for Clinics

____ **Yes** more than 6 clinic days per year $125.00 additional premium

____ **No,** I **do not** want coverage for clinics

STEP 2 CLINICS Premium: $_____

STEP 3: ASSISTANTS/PARTNERS

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 3 ASSISTANT Premium: $_____

STEP 4: VOLUNTEER/WORKING STUDENT PROGRAM

I want coverage for Volunteers/Working Students

____ **Yes**

1-6 per Month	Included	19-24 per Month	$375.00 additional premium
7-12 per Month	$125.00 additional premium	25-50 per Month	$500.00 additional premium
13-18 per Month	$250.00 additional premium	50+ per Month	Submit for Rate

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

STEP 4 VOLUNTEER Premium: $_____

STEP 5: BOARDING (with or without income) – Refer to Section 3

I want coverage for overnight Boarding

____ **Yes** ____ **No,** I **do not** want coverage for overnight boarding

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
$ 771.00	$ 974.00	$ 1365.00	$1911.00

Horses over 45 or GAR over $250,000 SUBMIT FOR RATE

STEP 5 BOARDING Premium: $_____

STEP 6: BREEDING (with or without income) –Refer to Section 3

a. **I want coverage for Breeding** *Professional Liability does not apply*

____ **Yes** $300.00- If receipts are over $50,000 Submit for Rate

____ **No,** I **do not** want coverage for breeding

STEP 6 BREEDING Premium: $ _____

STEP 7: 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 8: PERSONAL EQUINE LIABILITY

___ **Yes, I want coverage for Personal Equine Liability** $110 additional annual premium

___ **No, I do not want coverage for Personal Equine Liability**

STEP 8 PERSONAL EQUINE Premium: $_____

STEP 9: TOTAL ANNUAL POLICY PREMIUM * **TOTAL (add steps 1-8) $** _____

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

PAYMENT OPTIONS FORM

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

Applicant Name * _____ **Client Code** _____

Business/Club Name _____

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

Phone* _____ **Fax** _____

Email* _____ **** required***

___ **Request Quote Only (No payment enclosed)**

___ **Full Payment Credit Card (**complete authorization form on next page**)**

___ **Full Payment 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.**

Premium Down Payment: _____ **Credit Card (**complete authorization form on next page**)**

_____ **Check or Money Order (made payable to: *Equisure, Inc.*) $** _____

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.

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

FINANCE AUTHORIZATION

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

_____

Email address

CREDIT CARD AUTHORIZATION FORM

Return form with completed application if paying with a credit card. Print legible.

___ 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 _____