

**ANIMAL MORTALITY APPLICATION
for HORSES**



(Minimum Earned Premium = \$250.00)

Producer's Name _____	Applicant's Name _____
Agency Code <u>87 -</u>	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 Endorsement _____ (Policy Number)
(Coverage begins on the date of acceptance by the Company)

PLEASE READ: If you submit an INACCURATE and/or INCOMPLETE Application, the missing information will delay your coverage and the inaccurate information will result in claim denials and/or coverage reductions. The insurance you are applying for with this Application DOES NOT and WILL NOT cover Pre-Existing Conditions.

A. Horse Name	Date of Birth	Date of Purchase	*Purchase Price (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	All Uses	
Primary Stable Location:				
B. Horse Name	Date of Birth	Date of Purchase	*Purchase Price (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	All Uses	
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 \$10,000		Loss of Use-Limited	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Mortality - Limited		Major Medical \$15,000		AS&D/Stallion Infertility	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Major Medical \$5,000		Surgical \$5,000		Aggregate Deductible	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Major Medical \$7,500		Loss of Use		Other _____	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

	Horse A	Horse B
	Y	N
1. Was a pre-purchase exam completed? If yes, please attach a copy of the examination results.	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the horse been examined or treated by a veterinarian for any accident, injury, sickness, disease, and/or lameness within the last 24 months?	<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"/>
4. Has the horse undergone an ultrasound, bone scan, gastroscope, or x-rays within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the horse have any past conformational problems or defects, illness or disease, lameness, injury, or physical disability including, but not limited to: laminitis/founder, OCD, neurological disorders (e.g. EPM), navicular disease, kissing spine, arthritis, and/or degenerative joint disease?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the horse had a neurectomy or received any surgical treatment for lameness?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the horse received any long- or short-term medication or any preventative treatments in the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the horse received any joint injections in the last 24 months? If yes, Which joints? How often? Names of meds? Date of last injection?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the horse had any colic, colic surgery, impaction, gastric ulcers, or intestinal disorder within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>

		<u>Horse A</u>		<u>Horse B</u>	
		Y	N	Y	N
10.	If a mare, is the mare 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"/>
11.	If a mare, has the mare ever experienced birthing difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Does the horse have an ancestor known to carry HYPP? If No, please move on to question 13.	<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				
c.	Has the horse ever shown any HYPP signs or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

14. Who was each horse acquired from?

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

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

17. Method of payment? Cash Check Trade Other If Trade, provide details:

18. Are the horse(s) leased? Yes No If Yes, please attach a copy of the lease(s).

19. Is there or has there ever been any insurance on these horses that is similar to any insurance available on this Application?
Yes No If Yes, provide the carrier: _____
Expiration date: _____ Amount/Type of Coverage: _____
If Yes, Attach the Declarations Page, Schedule, and Loss Runs.

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

21. Have you lost any horse in the last 5 years (whether insured or not) 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:

22. Name, address, and telephone number of horse's primary licensed veterinarian:

23. **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 2,4,5,6,7,8,9, 11, and 12c. and any "No" answers to questions 3 and 23.

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)

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.

APPLICANT'S SIGNATURE

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

HARTFORD-CONTRACTED PRODUCER'S SIGNATURE

HARTFORD-CONTRACTED PRODUCER'S NAME
(Please Print)

STATE PRODUCER LICENSE NO.
(Required in Florida)