

## Renewal Application

Name and Address of Owner:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mobile Telephone: \_\_\_\_\_

Alternate Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

May we contact you by email regarding your policy? Yes ☐ No ☐

If an email is provided, your policy will be sent by email unless you check here. ☐

Name of Horse	Breed	Sex*	Exact Use	Insured Amount**
A.				
B.				
C.				
D.				

\*G-Gelding, M-Mare, S-Stallion

\*\* If requested value exceeds the purchase price, please provide explanation of value (i.e. competition record, training, etc.)

Loss Payee or Additional Insured Name/Address:

(Please indicate on which horses Loss Payee or Additional Insured Name applies.)

- Is the horse(s) currently sound and healthy for the use intended? Yes ☐ No ☐
- In the past 12 months, has the horse had any conformational problems, illness, disease, injury or lameness including but not limited to: laminitis/founder, OCD, neurological disorders, navicular disease, and/or degenerative joint disease? Yes ☐ No ☐
- Has the horse(s) had any colic or intestinal disorder within the last 12 months? Yes ☐ No ☐
- Has the horse(s) been nerved or received any surgical treatment for lameness? Yes ☐ No ☐
- Has the horse(s) received any diagnostic ultrasounds, x-rays, or bone scans in the last 12 months? Yes ☐ No ☐
- Has the horse(s) received any joint injections in the last 12 months? If yes, please specify joints injected, dates, and reasons for injections below. Yes ☐ No ☐
- Has the horse(s) received any type of medication long or short term, in the past 12 months? Yes ☐ No ☐
- Are there any other current or prior health conditions not declared above that the horse(s) was treated or examined for in the last 12 months? Yes ☐ No ☐
- Will the horse be outside the continental United States during the coverage period? If yes, please provide dates and locations for coverage consideration. Yes ☐ No ☐
- Mares only: Is the mare due to foal during the policy period? Yes ☐ No ☐  
If yes, due date: \_\_\_\_\_ Is this the mare's first foal? Yes ☐ No ☐

If the answer to #1 is "No", or the answer to #2-9 is "Yes", please specify the horse and provide details below. Include onset date, diagnosis, treatment, if the problem has been resolved, and when the horse returned to full work (attach a separate page if necessary). A Veterinarian's Statement of Examination must be completed if a covered animal required a veterinarian's care or treatment for illness or injury during the current policy period OR the limit of insurance exceeds \$100,000.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### COVERAGE DESIRED:

Horse:	A	B	C	D	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Full Mortality (includes Emergency Colic Surgery endorsement)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Major Medical/Surgical
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Only
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Use (x-rays required)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stallion Infertility (AS&D)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limited Mortality (Named Perils/Accidental death coverage only)

I understand and agree that the policy to be issued shall be founded upon the statements contained herein as well as prior information provided and shall be the basis of the contract, and if anything be falsely stated, or information withheld, to influence the Company's decision, the insurance shall be null and void.

Signature of owner (s) of above named animal \_\_\_\_\_

Date: \_\_\_\_\_

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