



APPLICATION FOR EQUINE INSURANCE

This is not a binder. No application will be considered if not fully completed and signed by the Insured

Coverage Date _____ Owner's Name (as it should appear on the policy) _____

Address _____ City _____ State _____ Zip _____

Mobile _____ Fax _____ E-Mail Address _____

Coverage Requested: <input checked="" type="checkbox"/> Mortality <input type="checkbox"/> Stallion Accident, Sickness & Disease <input type="checkbox"/> Perspective Foal to _____ <input type="checkbox"/> Loss of Use <input type="checkbox"/> Surgical Coverage <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> Guaranteed Renewal <input type="checkbox"/> 12 Month Ext <input checked="" type="checkbox"/> Agreed Value
Major Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$12,500 <input type="checkbox"/> \$15,000

Name & Registration/Tattoo # (Sire and Dam if unnamed)	DOB	Sex	Breed	Use	Purchase Date	Purchased From	Purchase Price	Insured Amount**

****Amounts other than purchase price are subject to Company acceptance****

Required Substantiation of value on any horse insured for more than the purchase price or if policy inception is more than 1 year from purchase.

Examples of substantiation include monthly training fees, current show records, breeding records, ect: _____

1. Are you the sole owner of the horse(s)? If not, list owners and addresses or lien holders/banks and address _____

If the horse is leased, please provide a copy of the lease.

2. Usual location of horse(s), give address and phone number _____

3. Name, address and telephone number of your usual veterinarian _____

4. Is there now any contagious or infectious disease on the premises, or has there been during the past 12 months? _____

5. Are horse(s) presently insured or previously? If yes to either questions, give name of company, date and amount _____

6. Has any company cancelled or refused to renew your coverage? If yes, give reason _____

7. Has any horse(s) owned by you died within the past 5 years (whether or not insured)? If yes, state number of deaths and causes of death _____

DECLARATION OF HEALTH:

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

1. (a) Does the horse(s) have any history of injury, illness, lameness or disease (including melanomas, sarcoids, warts or other types of growth)? If yes, give details, including date _____
(b) Does the horse(s) have any conformation issues that could affect its ability to be used for the intended use? If yes, give details _____
(c) Any laminitis/founder, OCD, navicular disease, degenerative joint disease and/or neurologic disorders? If yes, explain _____
2. (a) Has the horse(s) had any veterinary treatment including acupuncture or chiropractic (other than routine preventative vaccinations) or are they unsound in any way? _____
(b) Does the horse(s) receive any medications/supplements? If yes, explain _____
3. Has any horse(s) suffered from colic or any other gastro-intestinal related illness in the past 2 years? If yes, give details, including dates _____
4. Has any horse(s) been examined or treated by a veterinarian for other than routine care? If yes, explain and give dates. _____
5. (a) Has any horse(s) undergone surgery (other than castration), been fired, blistered or nerved? If yes, give details, including dates and results _____
(b) Has the horse(s) undergone diagnostic ultrasound, x-rays or bone scans within in the last 24 months? If yes, give details, including dates and results _____
6. Are any animals due to foal? If yes, what is the estimated date? _____
7. Has the horse received any joint injections? If yes, please provide details as to what drug was injected, where it was injected, how often injected, and details of the condition causing such injections to be given: _____

8. For all Quarter Horses, Appaloosas or Paint horses, does any horse(s) have an ancestor known to carry HYPP or HERDA? If yes, indicate the status for each horse (N/N, N/H, H/H) and if the horse is symptomatic? _____
9. (a) Is horse(s) on vaccination and worming program approved by a vet? (Yes/No) _____ Frequency? _____
(b) Has horse been vaccinated against West Nile Virus? (Yes/No) _____
10. Are there any other facts within your knowledge not already disclosed affecting or likely to affect the Company's acceptance of the proposed risk?

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 of Applicant

Date Signed

Signature of Producer (Office Use Only)

Agent

MARK EDWARD PARTNERS



PREMIUM PAYMENT OPTIONS (Please Check the Desired Method of Payment)

Installment payments are available for any premium over \$750. ACH/Credit Card information must be on file and authorized to run for all future installments at the time they are due.

- PAYMENT BY CHECK:** Make checks payable to **MARK EDWARD PARTNERS, LLC** and send in prior to policy inception or renewal expiration. Payments are to be mailed to **84 Business Park Dr. Suite 210, Armonk, NY 10504**

I hereby acknowledge that I am providing a check for my premium in the amount of \$_____.

- ACH WITHDRAWAL:** Please provide the following account information and our third party vendor, Simply Easier Payments will directly debit your checking or savings account.

Amount \$_____.

Routing #: _____ Account #: _____

Account Type: Checking _____ Savings _____

Flat \$2.95 for amounts up to \$5,000

.1% for any charges above \$5,000 (maximum fee is \$27.95)

- CREDIT CARD AUTHORIZATION/ NOTICE OF CREDIT CARD FEES**
(Master Card, Visa*, Discover, and American Express Accepted)

Card Number: _____ Zip Code Associated with Card _____

Expiration Date: ____/____/____ Code #: _____ Authorized Amount: \$_____

Contact phone number for any questions regarding this credit card: _____

Installment payments are available for any premium over \$750. A credit card must be on file and authorized to run for all future installments at the time they are due.

CREDIT CARD PROCESSING FEES

A Service fee will be collected by a 3rd party vendor, Simply Easier payments. The card processing fees are as follows:

Flat \$4.95 fee for charges up to \$165

3% for any charges above \$165

2-Payments (50% Up Front)

4-Payments (25% Each Payment)

Name on Card (Please Print): _____

Signature: _____ Date: _____