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| TO BE COMPLETED AND SIGNED **BY THE HORSE’S OWNER**. ALL VALUES ARE SUBJECT TO REVIEW BY UNDERWRITING. | | | | | | | | |
| **1.** | | **APPLICANT: OWNER** | | | | | | |
| NAME | | | | | EMAIL ADDRESS | | | |
| DO YOU HAVE AN EXISTING HEP POLICY?  YES NO POLICY NUMBER: | | | | | CELL/HOME PHONE NUMBER | | | |
| **2.** | | **HORSE INFORMATION** | | | | | | |
| NAME | | | SEX  GELDING:  STALLION / COLT:  MARE / FILLY:  MARE IN FOAL: | BREED | | USE | COLOUR | YEAR OF BIRTH |
| **I hereby confirm the horse is currently sound, healthy and free from any Medical Condition YES  NO** | | | | | | | | |
| **3.** | PLEASE READ CAREFULLY AND ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE | | | | | | | |

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| **To your knowledge, has the above horse:** | **YES** | **NO** |
| 1. Suffered from **ANY** form of colic or other intestinal or digestive disorder or stomach ulcers |  |  |
| 1. Undergone **ANY** surgery |  |  |
| 1. Had **ANY** past lameness, fractures, tendon, or ligament injury or **ANY** other accident, injury, illness, or disease |  |  |
| 1. Suffered from melanomas, sarcoids, warts or **ANY** other type of growth or tumor |  |  |
| 1. Received during the last 12 months, **ANY** attention from any Veterinarian, Veterinary Surgeon, Physiotherapist, Chiropractor or Acupuncturist for any reason other than routine vaccinations or obstetric work |  |  |
| 1. Received **ANY** other form of treatment for medical or preventative purposes (including corrective shoeing) |  |  |
| **Does the above horse have:** | **YES** | **NO** |
| 1. **ANY** objectionable habits, vices or behavioral issues |  |  |
| 1. **ANY** Injury, Illness, Disease or Medical Condition that should be brought to the company’s attention |  |  |

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| **4.** | | **EXPLAIN ANY YES ANSWERS – Include the month and year of the Medical Condition** | | | | | | |
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| **6.** | **VETERINARIAN INFORMATION** | | | | | | | |
| NAME OF REGULAR VETERINARIAN | | | | PHONE NUMBER | | | EMAIL ADDRESS | |
| I give permission for the company to contact my Veterinarian or Agent responsible for the horse to inquire about the health or treatment of the horse.  General Condition: The Horse must be vaccinated, and remain on a regular vaccination program administered by a Veterinarian | | | | | | | | |
| **7.** | | | | **EQUINE DISCLOSURE** | | | | | | |
| I understand and agree that immediate notice and full details of any accident, injury, illness, disease or medical condition, or death of the animal will be given to the Insurer. I agree that the signing and filing of this application does not bind the Insurer and no insurance shall be deemed effective unless and until this application is received and accepted by the Insurer and any binder of coverage shall then be effective only upon receipt by the Insurer. | | | | | | | | | | |
| **SIGNATURE OF APPLICANT** (Authorized for this purpose)  **X** | | | | | | **DATE** | **SIGNATURE OF APPLICANT** (Authorized for this purpose)  **X** | | **DATE** | |