

STATEMENT OF HEALTH FOR HORSE MORTALITY INSURANCE

This statement forms part of the Animal Mortality Application
(to be completed by the insured)

IMPORTANT NOTE: Completion and signing of this supplemental application in no way binds the Company to the risk or implies that coverage is in effect.

Name of Insured: _____ Name of Horse: _____
Use of Horse: _____ How long have you known horse? _____

1. Is the horse currently free of lameness and healthy, without the use of drugs, for the use intended? YES NO
Have you observed the horse in all gaits involved in its intended use? YES NO
2. 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 and/or degenerative joint disease? YES NO
3. Has the horse had any colic, impaction, colic surgery or intestinal disorders within the last 36 months? YES NO
4. Has the horse been nerved or received any surgical treatment for lameness? YES NO
5. Has the horse been examined or treated by a veterinarian for anything other than routine care within the last year? YES NO
6. Has the horse undergone diagnostic ultrasound, bone scan or x-rays within the last 36 months? YES NO
7. Has the horse received any joint injections, any type of medication long or short term or any preventative treatments in the last 24 months? YES NO
8. Has the horse been tested for HYPP? YES NO Results? NN NH HH
Appaloosas, Paints and Quarter Horses are required to be tested certainly if a progeny of the Impressive lineage; if sire or dam is NH or HH.; or if animals registration papers indicate NH or HH for NYPP.
9. Is the animal due to foal any time during the proposed policy period? If yes, give estimated foaling date along with the number of previous foals. YES NO
10. Was a pre-purchase exam done? (If yes, please attach a copy) YES NO
11. If yes, was answered to any question 2 through 8, please provide details below (attach additional paper, if necessary):

12. Has the feeding and supplement program changed in the last year? Explain: _____

13. Is feed and supplement program conducive to territory and use and not considered contributory to colic?
(Consult vet if necessary) _____

I understand and agree that the policy to be issued shall be founded upon this representation of owner contained herein. Prior policy information and this representation of owner 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.

Any person knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

Signature of owner(s) of above named animals _____ Date: (Must be no more than 30 days prior to policy effective date)

Fax completed statement to Johne Dobbs or Courtney Dobbs Clagg at 866-506-5361

Send completed Statement of Health to:
CClagg@Andreini.com
JDobbs@Andreini.com
Toll-Free Fax 866-506-5361



217.254.5261 ★ DobbsEquineIns.com