



# Standard All Risk Mortality & Theft Application

(Minimum policy premium \$200 fully earned.)

P.O. Box 2009 • Glen Allen, VA 23058-2009  
Phone: (800) 446-7925 (804) 965-1698 • Fax: (804) 527-7999  
Email applications to: mortalityapps@markelcorp.com

#64193 Insurance Marketplace Inc.

P O Box 6427 Lincoln NE 68506

If you would like to add a horse to an existing policy, indicate current policy number: \_\_\_\_\_

1. Named Insured - Full Name(s)/DBA: \_\_\_\_\_
2. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
3. Business Phone No: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_
4. Applicant is a member of:  None;  AHA;  AQHA;  APHA;  ARIA;  NRCHA;  NRHA;  USDF;  USEF;  USHJA;  Other: \_\_\_\_\_
5. Horse to be covered by this policy: \_\_\_\_\_ Total Number of horses owned: \_\_\_\_\_



Check here to receive your policy by email.

Name* & Registration #	Breed	Birth Date	Color	Sex	Use	Date Purchased	Purchase Price <sup>+</sup>	Amt of Insurance <sup>+</sup>

\* Provide name of sire & dam for unnamed foals. Provide photographs of unregistered horses.  
+ If amount of insurance does not equal purchase price/stud fee, attach full details including Substantiation of Value.

## 6. Optional Coverages

**Emergency Colic Surgery:** \$2,500 limit (\$0 deductible), automatically included on eligible policies /  \$5,000 limit (\$50 premium)

**Medical/Surgical or Surgical only** – Limit cannot exceed Mortality insured value.  
To qualify for Medical/Surgical coverage, the Mortality insured value must be at least 75% of the proven value of the horse. For example, you must purchase at least \$7,500 of mortality coverage, on a horse purchased for \$10,000. Rates may vary by state and coverage restrictions may apply. Not available for race horses or horses in race training and must be approved by an Underwriter.

**Medical/Surgical for all states (except FL)**  
Choose one of the following limits (Note: Premium may vary by state.)  
(with 20% copay)  
 \$5,000 limit - \$375 deductible     \$10,000 limit - \$500 deductible     \$15,000 limit - \$1,000 deductible

**Medical/Surgical for FL only**  
Choose one of the following limits  
(with no copay)  
 \$5,000 limit - \$375 deductible     \$10,000 limit - \$500 deductible     \$15,000 limit - \$1,000 deductible

**Surgical only**  \$5,000 limit; \$50 deductible; \$195 premium (Note: rates may vary by state)  
 \$10,000 limit; \$50 deductible; \$255 premium (Note: rates may vary by state; not available in FL)

**Limited Permanent Disability:** Available to performance horses (not all uses) greater than \$10,000 only.

**Personal Horse Liability:** Not applicable for commercial equine operations.

**Stallion Infertility Due to Accident, Sickness or Disease**

7. Would you like additional information on the following coverages?  Farm  Commercial Equine Liability  Horse Club  Umbrella
8. a.) Have you had any horse mortality, medical/surgical and/or liability claims or losses whether insured or not?  Yes  No  
b.) If yes, explain: \_\_\_\_\_
9. a.) Has any insurer ever refused, cancelled or non-renewed insurance for you or any of your owned horses?  Yes  No  
b.) If yes, provide full details: \_\_\_\_\_
10. a.) Are you insuring or have you insured other horses with another company/agency?  Yes  No  
b.) If yes, Company/Agency Name: \_\_\_\_\_ Expiration Date of Policy: \_\_\_\_\_
11. a.) Are you the sole owner of the horse(s)?  Yes  No  
b.) If no, other Owner's Name & Address: \_\_\_\_\_  
c.) Is the horse being leased? **If yes, contact our office for a Leased Justification of Value form.**  Yes  No
12. a.) Was purchase price  cash,  check,  trade  other: \_\_\_\_\_  
b.) If trade/other, provide full details including a copy of the Bill of Sale/Receipt. \_\_\_\_\_
13. List stud fee paid for all homebred foals: \$ \_\_\_\_\_
14. To your knowledge, have any of these horses suffered an accident, sickness or disease, had any veterinary treatment (apart from preventive inoculations) or have been unsound in any way? If yes, provide details on separate sheet.  Yes  No
15. a.) American Quarter /Paint/Appaloosa Horse: Does the horse have pedigree link to HYPP?  Yes  No  N/A  
b.) Test Results (Note: H/H horses are not insurable.): \_\_\_\_\_ c.) If N/H, has horse had any HYPP episodes?  Yes  No
16. a.) Name & location of person who has care, custody & control: \_\_\_\_\_ b.) Number of years of experience: \_\_\_\_\_
17. Name & phone number of regular vet: \_\_\_\_\_
18. Is horse on inoculation and worming program supervised by vet?  Yes  No If no, provide details: \_\_\_\_\_
19. Is horse in competition?  Yes  No If yes, how many times a year? \_\_\_\_\_ List classes/divisions: \_\_\_\_\_

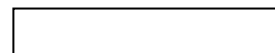
## Fraud Warning and Applicant Signature

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

I understand that **IMMEDIATE NOTICE** must be given to the Company upon any injury, illness, surgery, disease or death of an insured animal, and I agree to do so. I also understand that in the event of the death of an insured horse, a postmortem exam by a qualified veterinarian must be provided at my expense. **Sample policy wording can be provided upon request.** I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Applicant's Printed Name:** \_\_\_\_\_  
How did you hear about Markel: \_\_\_\_\_

Thank you for choosing Markel!



(Rev. 12/2015)

# Veterinary Certificate of Examination

<b>Named Insured:</b> _____		<b>Policy Number (if existing policy):</b> _____			
<b>Horse Name &amp; Tattoo Or Reg. No.</b>	<b>Breed</b>	<b>Age</b>	<b>Color</b>	<b>Sex</b>	<b>Sire/Dam</b>

**Owned by, if other than insured:** \_\_\_\_\_ **Location of animal(s):** \_\_\_\_\_

The horse being examined should be moved about outside of the stall to demonstrate soundness of limb and freedom of movement. Careful observation should be made as to housing conditions and the presence of contagious disease.  
**Please request additional form for permanent disability coverage.**

**TO THE VETERINARIAN:** Horses with a history of colic, founder or nerving may not be insurable. If there is evidence or knowledge of these problems, please provide all details. I, \_\_\_\_\_, **do certify that I am a graduate Veterinarian holding a current license to practice in \_\_\_\_\_ (indicate state).** **Are you the usual Veterinarian?**  Yes  No

<ol style="list-style-type: none"> <li>1. Pulse &amp; respiration normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>2. Temperature normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>3. Eyes clinically normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>4. Heart auscultated &amp; found normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>5. History or evidence of bleeder? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>6. History of evidence of nerving? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>7. Ever been treated for navicular disease, Arthritis, laminitis or founder? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>8. Any indication or history of lameness and/or faulty conformation? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>9. Any diagnostic procedures, including ultrasounds, x-rays, bone scans, etc...? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>10. Are any preventive treatment(s) / supplements used including, intramuscular and/or intravenous? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details: _____</li> <li>11. Are any Intra-articular Injections used? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details: _____</li> <li>12. Evidence of firing or blistering? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>13. Any conditions detrimental to satisfactory breeding? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>14. Ever been tested/treated for EPM? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date: _____ Results: _____</li> <li>15. Any episodes related to HYPP? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>16. Any indication of infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>17. Contagious disease on premises or in neighborhood? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>18. Any clinical evidence of objectionable vices or habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>19. Is the stabling and/or fencing adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>20. Have you discussed the horse's health history with the owner or caretaker? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>	<ol style="list-style-type: none"> <li>21. Has a complete pre-purchase or soundness exam been performed within the past 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(Provide details of any abnormal results.)</b></li> <li>22. To your knowledge, have any of these horses suffered an accident, sickness or disease, had any veterinary treatment (apart from preventive inoculations) or have been unsound in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, provide details on separate sheet.</b></li> <li>23. Subject to or any history of gastro intestinal/digestive disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>24. a.) Has any surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No b.) If yes, has horse fully recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, attach details on separate page.</b></li> <li>25. Is there likelihood of future danger to life or limb as a result of such surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>26. If male, are both testicles evident? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>27. Has horse been castrated? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>28. a. If female, is she reported in foal? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If in foal, give due date: _____</li> </ol> <p style="text-align: center;"><b>For foals 24 hours to 90 days of age, you must also complete the following questions.</b></p> <ol style="list-style-type: none"> <li>29. Was birth normal with no complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, attach details on separate page.</li> <li>30. Date and time of birth: _____</li> <li>31. Normal urination &amp; bowel movement? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>32. Has foal received any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>33. Is IgG/CBC normal on this date? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>
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Give complete details in regard to any the above questions that might have a bearing on the health or conformation or soundness of this horse: \_\_\_\_\_

Are any of these horses receiving any medication? If so, give details: \_\_\_\_\_

In addition, are there any other medical facts that you feel should be brought to the attention of the Company? \_\_\_\_\_

**Except as noted above, I certify that to the best of my knowledge & belief the horse is healthy & insurable sound.**

**Signature:** \_\_\_\_\_ **Phone Number:** (\_\_\_\_) \_\_\_\_\_ **Fax Number:** (\_\_\_\_) \_\_\_\_\_

**Address:** \_\_\_\_\_ **Date & Time of Exam:** \_\_\_\_\_

**This certificate must be received by the Company within 30 days of the exam date and/or prior to renewal.  
Please note the owner/agent is responsible for submitting this form to the Insurance Company.**



**Markel**  
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