

# STATEMENT OF HEALTH

## Horses Only



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| Producer's Name _____<br>Agency Code _____<br>Mail Address _____<br>City, ST Zip _____<br>Phone _____<br>Fax _____<br>E-mail Address _____ | Applicant's Name _____<br>Mail Address _____<br>City, ST Zip _____<br>Phone _____<br>Fax _____<br>E-Mail Address _____ |
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**This Statement forms part of the Animal Mortality Application for Horses.  
(To be completed by the applicant.)**

| Animal Name   | Date of Birth | Date of Purchase                                  | Purchase Price (or stud fee if raised) | Requested Limit of Insurance |
|---|---------------|---|--|------------------------------|
| <u>Identification</u> (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered) |               | <u>Sex</u> (Stallion, Mare, Colt, Filly, Gelding) | <u>Breed</u>                           | <u>Use</u>                   |

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| 1. | Has the horse been examined or treated by a veterinarian for any accident, injury, sickness, disease, lameness, or other than routine care within the last year? If YES, Please explain.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. | Is the horse currently free of lameness and healthy without the use of drugs? If NO, Please explain.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. | Has the horse undergone diagnostic ultrasound, bone scan, or x-rays within the last 12 months? If YES, Please explain.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. | Does the horse have any past conformational problems or defects, illness or disease, lameness, or injury or physical disability including, but not limited to: laminitis/founder, OCD, neurological disorders (e.g. EPM) navicular disease, and/or degenerative joint disease? If YES, Please explain. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. | Has the horse been nerved or received any treatment for lameness? If YES, Please explain.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. | Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 36 months? If YES, Please explain.  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. | Has the horse had any colic, colic surgery, impaction, or intestinal disorder within the last 12 months? If YES, Please explain.   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. | Is the horse due to foal any time during the requested Policy Period?<br>If Yes, please give:<br>Estimated Foaling Date: _____;    Number of Previous Foals: _____;    Stud fee: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. | Has the horse ever experienced birthing difficulties? (Mares only) If YES, Please explain  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I declare the above statements are true and complete, and that no material information was withheld.

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| Applicant's Signature | Date: (Must be no more than 30 days prior to policy effective date) |
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