



**LIVESTOCK INS.
SERVICES, INC.**

**P.O. BOX 1292
TERRELL, TX 75160
800-874-1789
972-563-6133 FAX
lcihorse@aol.com**

APPLICATION FOR HORSE MORTALITY INSURANCE
(This is NOT a binder.)

MARK COVERAGE DESIRED

- Full Mortality/Theft Restricted Perils
- Accident Only Agreed Value
- Major Medical Surgical
- \$5,000 \$7,500 \$10,000
- Stallion Infertility 12 month extension
- Emerg. Colic Surg. Transit Worldwide

Desired Eff. Date: _____

(TO BE COMPLETED BY THE INSURED)

NAME OF OWNER _____ ADDRESS _____
Street City State Zip Code County

HOME PHONE _____ CELL # _____ EMAIL _____ SS #: _____

New Policy? Add to existing policy? If so, Policy No. _____ BIRTH DATE: _____

Add'l Insd./Loss Payee/Lessor/Lessee? _____ Percent Ownership Interest? _____

***Use the following codes to indicate sex of animal: M - Mare; F - Filly; C - Colt; S - Stallion; G - Gelding**

Horse # 1 Name & Registration #	Sex	Color	Breed	Date of Birth	Exact Use & Function	Amount of Insurance Desired

Sire	Dam	Purchase Price	Purchase Date	Purchased From	Rate

- State nature of any illness or injury to above animal in the last 36 months. _____
- Have any horses owned by you died in the last 36 months? _____ Date: _____ Cause: _____
- Is this animal presently or has it previously been insured? _____ If yes, give expiration date, exact insured amount and company's name: _____
- Method of worming used? _____ How often? _____
- Describe your feeding & supplement program during specific seasons of the year as well as during the show/competition or breeding seasons.
 Summer feed: _____
 Winter feed: _____
 Breeding/Competition feed: _____
- Name of person having care, custody and control of horse if other than the named insured; _____
 Address and telephone # _____

7. Do you understand that immediate notification is required by telephone of any illness, injury, surgery, disease or death or your claim may be denied, and do you agree to do so? _____
8. Name, address and telephone number of your usual veterinarian: _____
9. Does the above listed animal(s) travel outside of the continental United States or Canada? _____ Where? _____
10. Name of Previous owner: _____

FRAUD CLAUSE

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR or VT; in DC, LA, ME, TN, VA and WA, insurance benefits may also be denied)

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE OF INSURANCE INFORMATION PRACTICE

Personal information about you may be collected from persons other than you. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties. You have the right to review your personal information in our file and can request correction of any inaccuracies. A more detailed description of your rights and our practices regarding such information is available upon request. Contact your agent or broker for instruction on how to submit a request to us.

I-We certify that the information shown on this application is true and correct.

Date _____ Applicant Signature _____
(No trainers or agents)

Agent Name (Print): _____ Agent Signature: _____

Agency Code # _____

Agent's License # _____



PO Box 1292
Terrell, TX 75160

Office (800) 874-1789 or (972) 563-6134 Fax (972) 563-6133 email: lcihorse@aol.com

STATEMENT OF HEALTH for HORSE MORTALITY INSURANCE

Name of Insured: _____ Name of Horse _____

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

	Y	N
1. Is the horse currently free of lameness and healthy, without the use of drugs, for the use intended? Have you observed the horse in all gaits involved in its intended use?		
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?		
3. Has the horse had any colic, impaction, colic surgery or intestinal disorders with the last 36 months?		
4. Has the horse been nerved or received any surgical treatment for lameness?		
5. Has horse been examined or treated by a veterinarian for other than routine care within the last year?		
6. Has the horse undergone diagnostic ultrasound, bone scan or x-rays within the last 36 months?		
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.		NA
8. Has the horse been tested for HYPP? Yes No Results? NN NH HH <i>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 animal's registration papers indicate NH or HH for HYPP.</i>		NA
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. Number of Previous Foals _____		
10. Was a pre-purchase exam done? (if "yes" please attach a copy)		
11. If "yes" was answered to any question 2 through 8, please provide date and description below _____ _____		
12. Has the feeding & supplement program changed in the last year? Explain _____		
13. Has the animal been vaccinated for the West Nile Virus?		
14. Have there been any cases of the West Nile Virus in your county?		
15. Are there any contagious diseases on the premises or in the area that pose a threat to the animal?		

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 is a crime.

Signature of owner(s) of above-named animal

Date