



# Declaration of Health

Policy Number: \_\_\_\_\_  
 Named Insured: \_\_\_\_\_  
 Phone: \_\_\_\_\_  Home  Work  Cell  
 Email: \_\_\_\_\_

Horse's Name	Registration #

**Request - Check all that apply:**

<input type="checkbox"/> Renew/Rebind Insurance	<input type="checkbox"/> Increase Value to: \$ _____ (Complete Substantiation of Value form.)	<input type="checkbox"/> Add Coverage: <input type="checkbox"/> Surgical Only OR <input type="checkbox"/> Medical/Surgical
---	---	---

**Health Questions**

1. Has horse suffered from any injury, illness, lameness or disease?  Yes  No
2. Has horse suffered from colic or any other gastro-intestinal related illness?  Yes  No
3. Has horse undergone surgery (other than castration) or been fired, blistered, nerved, treated or examined for lameness?  Yes  No
4. Has horse been examined by a veterinarian for anything other than routine care?  Yes  No
5. Does horse receive any medication?  Yes  No

**Details – If “yes” to any question #1-5 above, please provide details including date(s), diagnosis, treatment and recovery. Continue on separate sheet of paper if needed.**

---

---

---

---

---

---

---

---

*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.*

Signed:  Insured  Trainer  Manager \_\_\_\_\_ Date \_\_\_\_\_

*Note: The information given in this declaration should be provided by the person having care, custody and control of the animal and forms the basis of the insurance contract. Incorrect answers could invalidate the policy.*

**MARKEL • P.O. Box 2009, Glen Allen, VA 23058-2009 • Phone: (800) 446-7925 • Fax: (804) 527-7999  
 www.horseinsurance.com**