



Declaration of Health

P.O. Box 2009 • Glen Allen, VA 23058-2009
Phone: (800) 262-7535 • Fax: (804) 527-7999
www.horseinsurance.com

Insured's Name: _____

Policy Number: _____

Phone #: (____) _____ Fax #: (____) _____

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"/> <i>Surgical Only</i> <i>OR</i> <input type="checkbox"/> <i>Medical/Surgical</i>
--	---	---

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
 6. If mare, is horse in foal? Yes No
- 6a. If yes, due date: _____

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, the undersigned, declare that to the best of my knowledge and belief, the above are true and complete and that I have not withheld any material information. I further declare that no insurer has declined or refused to renew my insurance, and that there are no other circumstances within my knowledge not already disclosed which might affect the proposed insurance.

Signature: _____ Date: _____