THE HARTFORD
LIVESTOCK DEPARTMENT
www.hartfordlivestock.com

ANIMAL MORTALITY APPLICATION for HORSES

(Minimum Earned Policy Premium $250.00)

THE HARTFORD

Producer's Name	CORINTHIAN INSURANCE AGENCY, INC	Applicant's Name	
Agency Code	87 - 207650	Mail Address	
Mail Address	165 MAIN STREET, SUITE 214	City, ST Zip	
City, ST Zip	MEDWAY, MA 02053	Phone	
Phone	(508) 533-5103	Fax	
Fax	(508) 533-5109	E-Mail Address	
E-mail Address		Policy Term Desired **(maximum term 12 months)**:	

☒ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Limited Liability Corp. ☐ Other _____

Proposed Effective Date: _____ ☐ New Policy
(Coverage begins on the date of acceptance by the Company) ☐ Endorsement _____ (Policy Number)

Installment Payment Plans? ☐ Yes ☐ No
(Available on Premiums over $750)

A. Animal Name	**Date of Birth**	**Date of Purchase**	**Purchase Price** (or stud fee if raised)	**Mortality Limit (Agreed Value)**

Identification (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	**Sex** (Stallion, Mare, Colt, Filly, Gelding)	**Breed**	**Use**

Primary Stable Location:

B. Animal Name	**Date of Birth**	**Date of Purchase**	**Purchase Price** (or stud fee if raised)	**Mortality Limit (Agreed Value)**

Identification (Sire/Dam, Registration#, Tattoo#, Microchip#, or Pictures if unregistered)	**Sex** (Stallion, Mare, Colt, Filly, Gelding)	**Breed**	**Use**

Primary Stable Location:

All Limits of Insurance are subject to company approval.

For a Requested Limit of Insurance that does not equal the Purchase Price, complete and attach a **Substantiation of Value**.

Type of Coverage Requested:

A	B		A	B		A	B	
☐	☐	Mortality - Full	☐	☐	Major Medical $7,500	☐	☐	Loss of Use
☐	☐	Mortality - Limited	☐	☐	Major Medical $10,000	☐	☐	Loss of Use-Limited
☐	☐	Renewal Protection	☐	☐	Major Medical $15,000	☐	☐	Surgical $5,000 Limit
☐	☐	Major Medical $5,000, Basic	☐	☐	Major Medical $10,000 high deductible	☐	☐	Aggregate Deductible
☐	☐	Major Medical $7,500, Basic	☐	☐	Accident, Sickness and Disease (Stallions)	☐	☐	Other _____

		Horse A Y	Horse A N	Horse B Y	Horse B N
1.	Was a pre-purchase exam completed? If Yes, a copy of the examination results may be requested by the Company.	☐	☐	☐	☐
2.	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?	☐	☐	☐	☐
3.	Is the horse currently free of lameness and healthy without the use of drugs?	☐	☐	☐	☐
4.	Has the horse undergone diagnostic ultrasound, bone scan, or x-rays within the last 36 months?	☐	☐	☐	☐
5.	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?	☐	☐	☐	☐
6.	Has the horse been nerved or received any treatment for lameness?	☐	☐	☐	☐
7.	Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 36 months?	☐	☐	☐	☐
8.	Has the horse had any colic, colic surgery, impaction, or intestinal disorder within the last 36 months?	☐	☐	☐	☐
9.	Is the horse due to foal any time during the requested Policy Period? If Yes, please give: Estimated Foaling Date: _____; Number of Previous Foals: _____; Stud fee: _____	☐	☐	☐	☐
10.	Has the horse ever experienced birthing difficulties? (Mares only)	☐	☐	☐	☐
11.	Does the horse have an ancestor known to carry HYPP? If No, please move on to question **12**.	☐	☐	☐	☐
	a. Has the horse been HYPP tested? If Yes, please check the test results.	☐	☐	☐	☐
	N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B				
	b. Please check the HYPP test results of the horse's Sire and Dam.				
	Sire: N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B Unknown ☐A ☐B				
	Dam: N/N ☐A ☐B N/H ☐A ☐B H/H ☐A ☐B Unknown ☐A ☐B				
	c. Has the horse ever shown any HYPP signs or symptoms?	☐	☐	☐	☐

12. Will the horses be observed and cared for daily? ☐Yes ☐No If No, explain:

_____

13. Who was each horse acquired from?

14. Are you the sole owner of the horses? ☐Yes ☐No If No, provide other owner's % of interest, name and address:

15. Loss Payee(s): _____

(Name and Address)

16. If the Purchase Price was not paid entirely in cash, please describe the transaction in detail.

17. Are the horses leased to others? ☐Yes ☐No If Yes, please attach a copy of the lease(s).

18. Is there any other insurance on the horses? ☐Yes ☐No If Yes, provide the carrier name: _____

Expiration date: _____ Amount of coverage: _____

19. Has any insurance carrier ever canceled, non-renewed or refused to insure any horse in which you have or had an insurable interest? ☐Yes ☐No If Yes, provide details: (Not applicable in MO) _____

20. Have you lost any horse in the last 5 years (whether or not insured) or have any medical/surgical or colic claims been filed on the above listed horse? ☐Yes ☐No

If Yes, give date, cause, value and explain:

21. Name, address, and telephone number of the horse's primary licensed Veterinarian:

22. Do you understand that the insurance policy you are applying for requires you to give the Company immediate notice of any covered animal's death, injury, sickness, or disease, along with a description of the condition and the name of the attending veterinarian? Do you also understand that failure to give this immediate notice may result in the denial of a claim? ☐Yes ☐No

Please provide details for any **"Yes"** answers to questions 2,4,5,6,7,8,10 and 11c. and any **"No"** answers to questions 3 and 22.

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Note: A Veterinarian Certificate of Exam is required if:

1. **Horse is under 6 months of age**
2. **Horse is over 16 years of age**
3. **Horse is valued over $50,000**
4. **You have not known the horse over 30 days**
   (A pre-purchase exam no older than 30 days can be submitted in place of the vet exam)

☐ COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT.
(Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU INCONNECTION WITH THIS APPLICATION FOR INSURANCE. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY USOR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEWYOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS ANDOUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMITA REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE ORSTATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANYFACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVILPENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDINGTHE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS, IFFALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

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

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE ORBELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF,OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR ACLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TOCONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATIONCONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY ORANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FORTHE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BEA CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OFDEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THEANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HERKNOWLEDGE.

APPLICANTS SIGNATURE	DATE (Must be no more than 30 days prior to policy effective date)

PRODUCERS SIGNATURE	PRODUCERS NAME(Please Print)	STATE PRODUCER LICENSE NO. (Required in Florida)
	J. Scott Lombard	