



MARKEL INSURANCE COMPANY  
 P.O. Box 3870, Glen Allen, Virginia 23058-3870  
 (800) 446-7925 (804) 965-1698 Fax (804) 527-7999  
 www.horseinsurance.com

# Standard All Risk Mortality & Theft Application

(Minimum policy premium \$200 fully earned.)

Sue Fox of Insurance, Inc.  
 2 Park Center Court, Owings Mills, MD 21117  
 Phone: (800) 426-6220 Fax: (410) 753-1899 Home: (717) 235-4036  
 Email: sfox@insurance-inc.com Agent No.: 65153

If you would like to add a horse(s) to an existing policy, please indicate current policy number: \_\_\_\_\_

**(Applicant must be at least 18 years of age.)**

1. Named Insured - Full Name(s)/DBA: \_\_\_\_\_
2. Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone No.: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_
3. Business Phone No.: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Email Address: \_\_\_\_\_
4. Total Number of horses to be covered by this policy: \_\_\_\_\_ Total Number of Horses Owned: \_\_\_\_\_

Horse No.	Name* & Registration #	Breed	Birth Date	Color	Sex	Use	Date Purchased	Purchase Price*	Amount of Insurance*
1									
2									
3									

\* Provide name of sire & dam for unnamed foals. Provide photographs of unregistered horses.  
 + If amount of insurance does not equal purchase price/stud fee, attach full details including Substantiation of Value.

5. **Optional Coverages (NOTE: Rates may vary by state and coverage restrictions may apply.)**

<b>Choose One:</b> <input type="checkbox"/> Medical / Surgical Plan 1** <b>OR</b> <input type="checkbox"/> Medical / Surgical Plan 2**	\$8,000 limit per horse per policy term, up to 15 years old  Plan 1: \$232 Premium (\$500 Deductible, 25% co-pay)  Plan 2: \$351 Premium (\$250 Deductible)	<i>Apply coverage to:</i> <input type="checkbox"/> Horse 1, <input type="checkbox"/> Horse 2, <input type="checkbox"/> Horse 3
<input type="checkbox"/> Surgical**	Available to horses up to 18 years old. \$140 Premium, \$50 deductible, \$5,000 limit	<i>Apply coverage to:</i> <input type="checkbox"/> Horse 1, <input type="checkbox"/> Horse 2, <input type="checkbox"/> Horse 3
Please call for further details: <input type="checkbox"/> <b>Permanent Disability</b> – Available to performance horses (not all uses) greater than \$10,000 only. <input type="checkbox"/> <b>Personal Horse Liability</b> – Not applicable for commercial equine operations. <input type="checkbox"/> <b>Stallion Infertility Due to Accident, Sickness or Disease</b>		

\*\* Not available for race horses or horses in race training and must be approved by an Underwriter. Rates may vary by state.

6. a.) Have you had any horse mortality, medical/surgical and/or liability claims or losses whether insured or not?  Yes  No  
 b.) If yes, please explain: \_\_\_\_\_
7. a.) Has any insurer ever refused, cancelled or non-renewed insurance for you or any of your owned horses?  Yes  No  
 b.) If yes, provide full details: \_\_\_\_\_
8. a.) Are you insuring or have you insured other horses with another company/agency?  Yes  No  
 b.) If yes, Company/Agency Name: \_\_\_\_\_ Expiration Date of Policy: \_\_\_\_\_
9. a.) Are you the sole owner of the horse(s)?  Yes  No  
 b.) If no, other Owner's Name & Address: \_\_\_\_\_  
 c.) Is the horse being leased?  Yes  No **If yes, please contact our office for a Leased Justification of Value form.**  
 d.) If yes, Name & address of loss payee/lessee: \_\_\_\_\_

**Please write in black ink.**

10. a.) Was purchase price  cash,  check,  trade  other: \_\_\_\_\_  
 b.) If trade/other, provide full details including a copy of the Bill of Sale/Receipt. \_\_\_\_\_
11. List stud fee paid for all homebred foals: \$ \_\_\_\_\_
12. To your knowledge, have any of these horses suffered an accident, sickness or disease, had any veterinary treatment (apart from preventive inoculations) or have been unsound in any way?  Yes  No *If yes, provide details on separate sheet.*
13. a.) American Quarter Horse/Appaloosa/American Paint Horse: Does the horse have a pedigree link to HYPP?  Yes  No *If no, go to #14.*  
 b.) Test Date: \_\_\_\_\_  
 c.) Test Results (**Note: H/H horses are not insurable.**): \_\_\_\_\_  
 d.) If N/H, has horse had any HYPP episodes?  Yes  No
14. a.) Name and location of person who has care, custody and control: \_\_\_\_\_  
 b.) Number of years of experience: \_\_\_\_\_  
 c.) Age, type and condition of building and fencing: \_\_\_\_\_
15. If horses are not stabled, are they kept in an open pasture?  Yes  No
16. a.) Are video monitors used for foal watch?  Yes  No  
 b.) Is transportation readily available for emergencies?  Yes  No
17. Name and phone number of regular vet: \_\_\_\_\_
18. Is horse on inoculation and worming program supervised by vet?  Yes  No *If no, provide details:* \_\_\_\_\_  
 \_\_\_\_\_
19. a.) How many miles to closest surgical facility? \_\_\_\_\_  
 b.) Is regular vet on staff there?  Yes  No
20. Is horse in competition?  Yes  No *If yes, how many times a year?* \_\_\_\_\_ *List classes/divisions:* \_\_\_\_\_
21. a.) Is horse used in rodeo events?  Yes  No                      b.) Is horse shipped more than 12 times a year?  Yes  No  
 c.) Is horse shipped more than 200 miles any trip?  Yes  No            d.) Does mare or stallion travel to be bred?  Yes  No
22. Indicate if you are interested in the following coverages:  Liability  Farm  Care, Custody & Control  Riding Club  Umbrella

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, insurance benefits may also be denied.

I understand that **IMMEDIATE NOTICE** must be given to the Company upon any injury, illness, surgery, disease or death of an insured animal, and I agree to do so. I also understand that in the event of the death of an insured horse, a postmortem exam by a qualified veterinarian must be provided at my expense. **Sample policy wording can be provided upon request.**

*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.*

**Applicant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Applicant's Printed Name:** \_\_\_\_\_

**How did you hear about Markel?** \_\_\_\_\_

*Thank you for choosing Markel, The Insurance Company with Horse Sense!®*



Veterinary Certificate of Examination

Named Insured: \_\_\_\_\_ Policy Number (if existing policy): \_\_\_\_\_

The horse being examined should be moved about outside of the stall to demonstrate soundness of limb and freedom of movement. Careful observation should be made as to housing conditions and the presence of contagious disease.

Please request additional form for permanent disability coverage.

TO THE VETERINARIAN: Horses with a history of colic, founder or nerving may not be insurable. If there is evidence or knowledge of these problems, please provide all details. I, \_\_\_\_\_, do certify that I am a graduate Veterinarian holding a current license to practice in \_\_\_\_\_ (indicate state) and that I have this date and time examined:

Table with 7 columns: Horse #, Name & Tattoo Or Reg. No., Breed, Age, Color, Sex, Sire/Dam. Rows 1-3.

Owned By: \_\_\_\_\_

Location of animal(s): \_\_\_\_\_

Form with columns for 'Indicate Horse Number(s) Yes No' and 22 numbered questions regarding horse health and examination.

	Indicate Horse Number(s)			Indicate Horse Number(s)	
	Yes	No		Yes	No
23. To your knowledge, have any of these horses suffered an accident, sickness or disease, had any veterinary treatment (apart from preventive inoculations) or have been unsound in any way? <i>If yes, please provide details on separate sheet.</i>	_____	_____			
24. Subject to or any history of gastro intestinal/digestive disorders?	_____	_____			
25. a.) Has any surgery been performed? b.) If yes, has horse fully recovered? If yes, attach details on separate page.	_____	_____	30. Was birth normal with no complications? If no, attach details on separate page.	_____	
26. Is there likelihood of future danger to life or limb as a result of such surgery?	_____	_____	31. Date and time of birth:	_____	
27. If male, are both testicles evident?	_____	_____	32. Normal urination & bowel movement?	_____	
28. Has horse been castrated?	_____	_____	33. Has foal received any medication?	_____	
29. a. If female, is she reported in foal? b. If in foal, give due date: _____	_____	_____	34. Is Igg/CBC normal on this date?	_____	

Give complete details in regard to any of the above questions that might have a bearing on the health or conformation or soundness of this horse: \_\_\_\_\_

Are any of these horses receiving any medication? If so, give details: \_\_\_\_\_

In addition, are there any other medical facts that you feel should be brought to the attention of the Company? \_\_\_\_\_

**Except as noted above, I certify that to the best of my knowledge and belief that the horse(s) is/are healthy and insurable sound.**

Signature: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Date & Time of Exam: \_\_\_\_\_

**This certificate must be received by the Company within 30 days of the exam date and/or prior to renewal.**

**Please note the owner/agent is responsible for submitting this form to the Insurance Company.**



P.O. Box 3870, Glen Allen, Virginia 23058-3870  
(800) 446-7925 (804) 965-1698 Fax (804) 527-7999