



EDGE EQUINE

A division of Edge & Associates, Inc.

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Statement of Health

Name of Insured: _____ Phone Number: _____

Address: _____

Name of Horse: _____ Breed: _____ Height: _____ Sex: _____ Date of Birth: _____

Horse's Exact Use: _____ Level: _____ Insured Value†: _____

† Insured amount should not exceed the horse's current fair market value.

Name of any previous insurance company: _____ Desired Effective Date: _____

Loss Payee or Additional Insured Name: _____

- | | | |
|--|------------------------------|-----------------------------|
| 1. Is the horse currently sound and healthy for the use intended? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. For all Quarter Horses, Appaloosas, or Paint horses.
Does the horse have an ancestor known to carry HYPP? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If "Yes" is answered, please indicate the HYPP status. (Circle one.)
(Note: Coverage will not be considered without the disclosure of HYPP status.) | N/N | N/H H/H |
| 3. Does the horse have any past or present conformation problems, defects or ailments, illness or disease, lameness, injury or physical disability including but not limited to: laminitis/founder, OCD, neurological disorders, navicular disease, and/or degenerative joint disease? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Has the horse had any colic or intestinal disorder within the last 36 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Has the horse been nerved or received any surgical treatment for lameness? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Has the horse been examined or treated by a veterinarian for other than routine care within the last year? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Has the horse undergone diagnostic ultrasounds, X-rays, or bone scans within the last 36 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Does the horse receive any other medications/supplements? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Are there any other current or prior health conditions to which the horse has been exposed? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**If "yes" was answered to any question(s) 3 through 10, please provide details below.
Include onset date, diagnosis, treatment, how condition resolved, and when the horse returned to full work.**

I understand and agree that the policy to be issued shall be founded upon the statements contained herein and prior policy information and this statement 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.

Signature of owner (s) of above named animal

Date: _____
(must be no more than 30 days prior to policy effective date)

Additional Coverages Available	
<input type="checkbox"/> Major Medical/Surgical (annual limit \$7,500, not to exceed the horse's insured mortality limit) – Premium is Fully Earned.	<input type="checkbox"/> External Injury Only Loss of Use (Plan B)
<input type="checkbox"/> Major Medical/Surgical (annual limit \$10,000) – Premium is Fully Earned.	<input type="checkbox"/> Stallion Infertility for A, S & D
<input type="checkbox"/> Surgical Only – Premium is Fully Earned.	<input type="checkbox"/> Third Party Liability
<i>Standard mortality policy includes Colic Surgery Coverage, Guaranteed Extension, and Value Endorsement.</i>	