

XL SPECIALTY INSURANCE COMPANY - EQUINE DECLARATION OF HEALTH

TO BE COMPLETED AND SIGNED BY THE OWNER OR PERSON RESPONSIBLE FOR THE HORSE

Name of Horse: \_\_\_\_\_ Breed: \_\_\_\_\_ Sex: \_\_\_\_\_

Sire: \_\_\_\_\_ Dam: \_\_\_\_\_

Year of birth: \_\_\_\_\_ Use: \_\_\_\_\_

Name of Owner: \_\_\_\_\_ Sum Insured: \_\_\_\_\_

Please answer the following questions to the best of your knowledge and ability by checking the appropriate box, if you need more space to answer please use the back of this form.

1) Has the above horse ever suffered from any form of colic or other intestinal or digestive disorder, or fracture, lameness, tendon or ligament injury, accident, illness or disease or undergone any surgery (including castration if within the last twelve months) while in your \*ownership/care or before? (\* delete as applicable)

Yes  No

If YES give details including recovery status: \_\_\_\_\_

2) Has there been any evidence of contagious or infectious disease during the past twelve months in the location where the horse is kept?

Yes  No

If YES give details including current status: \_\_\_\_\_

3) During the last twelve months has the above horse received attention from any Veterinarian, Physiotherapist, Chiropractor, Acupuncturist or Homoeopaths for any reason other than routine vaccination or obstetric work, or received any other form of treatment for remedial purposes including farriery, and is the horse currently receiving any non-steroid anti-inflammatory or analgesic medication?

Yes  No

If YES give details including recovery status: \_\_\_\_\_

4) Has the above horse ever suffered from melanomas, sarcoids, warts or any other type of growth?

Yes  No

If YES give details including current status: \_\_\_\_\_

5) Has horse been vaccinated against West Nile Virus? Yes  No

6) If mare, is she in foal? Yes  No

If YES, give last service date and stallion: \_\_\_\_\_

If NO, give reason: \_\_\_\_\_

7) To the best of your knowledge is the above horse at present normal in conformation, eyes, heart, wind and action and in good health and does it therefore in your opinion represent a normal risk for mortality insurance purposes for the use described above?

Yes  No

If No give details: \_\_\_\_\_

I hereby certify that to the best of my knowledge and belief the above particulars are true and correct and that no information which could materially affect this insurance has been knowingly withheld.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

NAME (please print) \_\_\_\_\_

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.



# Health Condition Information Form (Part B)

Name of Insured: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Horse: \_\_\_\_\_

Exact Use: \_\_\_\_\_

Our records indicate this horse has been treated for an injury, illness or disease during the policy year. For underwriting purposes please be as specific as possible when completing the information request below. A veterinarian narrative or report may also be included with this form. Please address each health issue with as much detail as possible.

Condition reported: \_\_\_\_\_

*(example: bad breath 1 possible dental / tooth issue)*

Onset date of condition: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Date(s) and treatment(s) required / provided: \_\_\_\_\_

Current status: \_\_\_\_\_

How / when condition resolved? \_\_\_\_\_

Is this horse back to showing/ competition? \_\_\_\_\_

Yes  No

If yes please provide current show / competition records: \_\_\_\_\_

Does the horse currently receive/require any medications/supplements/treatments to prevent reoccurrence?  Yes  No

If YES please provide type and frequency: \_\_\_\_\_

Additional details/ comments: \_\_\_\_\_

\_\_\_\_\_  
DATE SIGNED

\_\_\_\_\_  
SIGNATURE OF PERSON COMPLETING THE FORM