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American Home Assurance Company
Insurance Company of the State of Pennsylvania

EQUINE INSURANCE APPLICATION
THIS IS NOT A BINDER

Specialty Program Insurers, Inc
 4300 Shawnee Mission Parkway
 Fairway, KS 66205
 Phone (800) 338-3313 Fax (913) 676-9358

IMPORTANT: No application will be considered if not fully completed and signed by the Assured within 20 days of inception.
Coverage is considered as "applied for" when the applicant has signed and dated this form.

NAME OF APPLICANT		COVERAGE(S) DESIRED	
STREET		<input type="checkbox"/> Major Medical (select one)	<input type="checkbox"/> Agreed Value
CITY/STATE/ZIP CODE		<input checked="" type="checkbox"/> Mortality	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
TELEPHONE NUMBERS		(Not all coverages are available on all breeds/uses- please check with your agent)	<input type="checkbox"/> 12 Months Extension
Home: ()	Work: ()	<input type="checkbox"/> Surgical (select one):	<input type="checkbox"/> Loss of Use
		<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Other
		POLICY PERIOD REQUESTED	
		(12:01am Standard Time) From _____ To _____	
		If Kentucky, please check if this address is within the city limits <input type="checkbox"/>	
		Email Address: _____	

AMOUNTS OF INSURANCE IN EXCESS OF PURCHASE PRICE ARE SUBJECT TO COMPANY ACCEPTANCE. VALUE SUBSTANTIATION MUST BE PROVIDED.

NAME AND REGISTRATION / SIRE & DAM (A photo is required for unregistered animals.)	AGE (DOB if under 1 year)	SEX			BREED	USE	DATE OF PURCHASE	PURCHASE PRICE	REQUESTED AMOUNT
		Male	Female	Castrated Male					
1)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			/ /		
2)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			/ /		
3)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			/ /		

- Percentage of ownership Give name and _____
 100% or _____ % address of _____
 other owner(s): _____
- Was purchase price paid by cash, trade, or both? Give particulars: _____
- Are animals financed or leased? Yes No
 Name and address of Loss Payee: _____
- Are animals healthy and capable of performing intended use? Yes No
 If no, describe: _____
- Quarterhorse, Appaloosa & Paint Horses: Is animal a Halter Horse? Yes No
- Has animal been treated for an accident, illness, lameness, or colic Yes No
 in the last 3 years? If yes, provide details: _____
- Are animals on inoculation and worming program supervised by a vet? Yes No
 If no, explain: _____
- Are animals now insured? Yes No Previously insured? Yes No
 If yes to either, what company and amount insured: _____
- Has any company cancelled or refused to renew your coverage? Yes No
 If yes, give company, date, and reason given for company action: _____

- Has any horse owned by you died in the past three years? Yes No
 If yes, state cause of death: _____
 Was there insurance? Yes No What company? _____
- Are you insuring other horses with another company? Yes No
 If so, which company: _____
- Name and telephone number of your regular veterinarian: _____
- How long has this veterinarian treated the horse(s)? _____

Health Statement: Is acceptable for: non-racing horses, valued at \$25,000 or less, age 31 days of age through 15 years old, not requesting Loss of Use coverage and horses that have not had any illness, injury, lameness, disease or surgery in the past twelve months. A satisfactory veterinarian certificate is required for all others.

The undersigned, hereby affirms that the aforescribed animal(s) are in good health and have not had any illness, injury, surgery or loss of foal (if broodmare) during the past 12 months, to the best of my knowledge and belief. I understand that Underwriters are issuing insurance in reliance upon the information I am now disclosing.

Standard: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may subject such person to criminal and civil penalties.
For New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
For Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
For Virginia Applicants: It is a crime to knowingly provide false, incomplete information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I understand that the insurance being applied for, if accepted by the Company, will be based on the statements made in this application. If information is withheld or falsely stated, any insurance issued may be subject to rescission or modification as provided by the law of the state in which the application was accepted or the policy issued.

APPLICANT'S SIGNATURE
 X

DATE
 / /

COVERAGE IS CONSIDERED AS "APPLIED FOR" WHEN THE APPLICANT HAS SIGNED AND DATED THIS FORM