



2130 Point Boulevard, Suite 150 • Elgin, IL 60123 • Phone 800.734.0598 • Fax 847.844.8284 • info@hallmarkhorse.com • www.hallmarkhorse.com

Renewal Application

Name and Address of Owner: _____

E-mail: _____

I prefer to receive my policy by: e-mail mail

Home Phone: _____

Work / Cell Phone: _____

Last Year's Policy Number: _____

Desired Effective Date: _____

Name of Horse	Breed	Sex*	Exact Use	Level	Date of Birth	Purchase Date	Purchase Price	Insured Amount**†
A.								
B.								
C.								
D.								

*G-Gelding, M-Mare, S-Stallion

** If requested value exceeds the purchase price, please provide explanation of value (i.e. competition record, appraisal, training, etc.)

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

Loss Payee or Additional Insured Name: _____

(Please indicate on which horses Loss Payee or Additional Insured Name applies.)

1. Is the horse(s) currently sound and healthy for the use intended? Yes No
2. For all Quarter Horses, Appaloosas, or Paint horses.
Does any horse have an ancestor known to carry HYPP? Please indicate "Yes" or "No" for each horse.
If "Yes" is answered for any horse, please indicate the HYPP status (N/N, N/H, H/H) for each horse.
(Note: Coverage will not be considered without the disclosure of HYPP status.)
3. Does the horse(s) 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 No
4. Has the horse(s) had any colic or intestinal disorder within the last 36 months? Yes No
5. Has the horse(s) been nerved or received any surgical treatment for lameness? Yes No
6. Has the horse(s) been examined or treated by a veterinarian for anything **other** than routine care within the last year? Yes No
7. Has the horse(s) undergone diagnostic ultrasounds, X-rays, or bone scans within the last 36 months? Yes No
8. Has the horse(s) received any joint injections in the last 12 months? If yes, please specify joints injected, dates, and reasons for injections below. Yes No
9. Has the horse received any type of medication long or short term, or any preventative treatments in the last 12 months? Yes No
10. Does the horse(s) receive any other medications/supplements? Yes No
11. Are there any other current or prior health conditions to which the horse(s) has been exposed? Yes No
12. Will any horse be outside the continental United States or Canada during the coverage period? Yes No

If the answer to question 1 is "No" for any horse, please indicate the horse and provide details below. If "Yes" was answered to any question 3 through 11, please indicate the horse and provide details below. Include onset date, diagnosis, treatment, how condition resolved, and when the horse returned to full work. For question 12, provide details including dates and locations for coverage consideration.

Please attach updated information on the horse(s) show/competition record, training, or breeding information.

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.

Date: _____

Signature of owner (s) of above named animal _____

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

Horse:	A	B	C	D	Additional Coverages Available
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Major Medical and Surgical (annual limit \$7,500, not to exceed the horse's insured mortality limit) – Premium is Fully Earned
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Major Medical and Surgical (annual limit \$10,000) – Premium is Fully Earned
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Only – Premium is Fully Earned
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colic Medical and Surgical – Premium is Fully Earned
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	External Injury Only Loss of Use (Plan B)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stallion Infertility for A, S & D
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Third Party Liability
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Territorial Limits Including Transit (Must complete question 12 above.)

Standard mortality policy includes Colic Surgery Coverage, Guaranteed Extension, and Value Endorsement.



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Please be sure to complete the following when renewing.

1. Sign the application
2. Date the application -**You must sign and date this form no more than 30 days prior to the expiration date of your policy.**
3. Explain any injury, illness, disease or accident that occurred in the last 36 months and whether or not that condition has resolved.
4. Enclose veterinary certificate (if required).
5. Enclose payment by check, or give instructions for payment by credit card below.

COMMENTS - Please use this section if you need to address a specific change on the policy or health concern.

Credit Card Payment Information

Please charge my premium to: VISA MASTERCARD DISCOVER AMEX

Amount: \$ _____

Credit Card Number: _____ Exp. Date: _____ / _____

OR Please call me at (_____) _____ for my credit card number.

Customer Signature: _____

Payment Plans

Payment plans are available. Please note a \$25 - \$40 administration charge applies to the first payment. If you would like a payment plan, please call our office to make arrangements.