



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 of Insured: \_\_\_\_\_ Contact #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ I prefer to receive my policy by: e-mail  mail

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

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.

Last Year's Policy Number: \_\_\_\_\_ Desired Effective Date: \_\_\_\_\_

Loss Payee or Additional Insured Name: \_\_\_\_\_

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

If "yes" was answered to any question(s) 3 through 11, please 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 provide 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.

\_\_\_\_\_  
**Signature of owner (s) of above named animal**

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

<b>Please Check Additional Coverages Desired</b>	
<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"/> Major Medical and Surgical (annual limit \$10,000) – Premium is Fully Earned <input type="checkbox"/> Surgical Only – Premium is Fully Earned <input type="checkbox"/> Colic Medical and Surgical – Premium is Fully Earned	<input type="checkbox"/> External Injury Only Loss of Use <input type="checkbox"/> Stallion Infertility for A, S & D <input type="checkbox"/> Third Party Liability <input type="checkbox"/> Territorial Limits Including Transit <small>(Must complete question 12 above.)</small>
<i>Standard mortality policy includes Colic Surgery Coverage, Guaranteed Extension, and Value Endorsement.</i>	



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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.*

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**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.