



Statement of Health

Name of Insured: Mike & Mary Sypolt MM Dream Farm Phone Number: _____

Address: 9899 Trailhead Court City: Wilton State: CA Zip: 95693

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 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. 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, illnesses or disease, lameness, injury or physical disability including but limited to: laminitis/founder, OCD, neurological disorders, navicular disease, and/or degenerative Joint disease? Yes No
4. Has the horse has 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 **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 medications 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 conditions resolved, and when the horse returned to full work. For question 12, provide details including dates and locations for coverage consideration.

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 the insured 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"/> Major Medical/Surgical (annual limit \$10,000) – Premium is Fully Earned <input type="checkbox"/> Surgical Only – Premium is Fully Earned	<input type="checkbox"/> External Injury Only Loss of Use (Plan B) <input type="checkbox"/> Stallion Infertility for A, S & D <input type="checkbox"/> Third Party Liability <input type="checkbox"/> Territorial Limits Including Transit
<i>Standard mortality policy includes Colic Surgery Coverage, Guaranteed Extension, and Value Endorsement. 1.1.07</i>	