



# Jacobi Group

1395 S. Bates Lane  
Cottonwood, AZ 86326  
1-800-355-4868

## Statement of Health

Name of Insured: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Name of Horse: \_\_\_\_\_ Breed: \_\_\_\_\_ Height: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Horse's Exact Use: \_\_\_\_\_ Level: \_\_\_\_\_ Insured Value<sup>+</sup>: \_\_\_\_\_

<sup>+</sup> 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 <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 2. For all Quarter Horses, Appaloosas, or Paint horses.<br>Does the horse have an ancestor known to carry HYPP?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| If "Yes" is answered, please indicate the HYPP status. (Please check one.)<br>(Note: Coverage will not be considered without the disclosure of HYPP status.)   |                              |   |
|  | <input type="checkbox"/> N/N | <input type="checkbox"/> N/H <input type="checkbox"/> H/H |
| 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 <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 4. Has the horse had any colic or intestinal disorder within the last 36 months?   | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 5. Has the horse been nerved or received any surgical treatment for lameness?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 6. Has the horse been examined or treated by a veterinarian for anything <b>other</b> than routine care within the last year?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 7. Has the horse undergone diagnostic ultrasounds, X-rays, or bone scans within the last 36 months?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 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 <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 9. Has the horse received any type of medication long or short term, or any preventative treatments in the last 12 months?   | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 10. Does the horse receive any other medications/supplements?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 11. Are there any other current or prior health conditions to which the horse has been exposed?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |
| 12. Will the horse be outside the continental United States or Canada during the coverage period?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                               |

**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.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_  
(no more than 30 days prior to policy effective date for new apps)  
(no more than 45 days prior to policy effective date for renewals)

Additional Coverages Available	
<input type="checkbox"/> Equine Catastrophic Accident and Illness (annual limit \$5,000)	<input type="checkbox"/> External Injury Only Loss of Use
<input type="checkbox"/> Equine Medical and Surgical (annual limit \$7,500, not to exceed the horse's insured mortality limit)	<input type="checkbox"/> Stallion Infertility for A, S & D
<input type="checkbox"/> Equine Medical and Surgical (annual limit \$10,000)	<input type="checkbox"/> Third Party Liability
<input type="checkbox"/> Equine Medical and Surgical (annual limit \$15,000)	<input type="checkbox"/> Territorial Limits Including Transit
Standard mortality policy includes Colic Surgery Coverage, Guaranteed Extension, and Value Endorsement.	
(Must complete question 12 above.)	