



# Declaration of health

## Markel Insurance Company

P.O. Box 2009, Glen Allen, VA 23058-2009

Email form to: [horseinsurance@markel.com](mailto:horseinsurance@markel.com)

Phone: 1.800.446.7925 Fax: 1.804.527.7999

Insured's name: \_\_\_\_\_ Submission or policy number: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Horse's name: \_\_\_\_\_

### Section 1 - Health history

1. If mare, is the horse in foal?  Yes  No If yes, due date: \_\_\_\_\_

2. Does your horse have any history of the following health conditions?  Yes  No

If yes, check all that apply:

- Injury, illness, lameness, or disease
- Colic or any other gastro-intestinal related disease
- Conformation defects
- Surgery
- Castration
- Receives medication
- Seen by veterinarian for anything other than routine care

**Provide details including date(s), diagnosis, treatment and recovery.** (If additional is needed, use a separate page.)

### Section 2 - Policy request (check all that apply)

- Renew/Rebind insurance
- Increase/Decrease value to: \$ \_\_\_\_\_ (complete justification of value form)
- Add or change coverages:
  - Surgical only – limit:  \$5,000  \$10,000
  - Medical/surgical – limit:  \$5,000  \$10,000  \$15,000; deductible:  \$375  \$500  \$1,000
  - Increase emergency colic surgery - limit:  \$7,500  \$10,000
  - Equine Essentials -
    - Option 1 - \$2,500/\$5,000\* owned horse equipment
    - Option 2 - \$5,000/\$10,000\* owned horse equipment
    - Option 3 - \$7,500/\$15,000\* owned horse equipment
  - Private horse owner liability - limit:  \$300,000  \$1,000,000

By checking this box, I confirm my horse(s) covered under this policy is/are used for private/personal use ONLY and are not used for hire in public trail rides, lesson programs or camps by a third party.

**Agreement:** The undersigned is an authorized representative of the applicant and represents that reasonable inquiry has been made to obtain the answers to questions on this form. He/she represents that the answers are true, correct, and complete to the best of his/her knowledge. The undersigned authorized representative agrees that if the information supplied on the application changes between the date of the application and the effective date of the insurance, he/she will immediately notify the Company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Before signing this document, verify your information is correct. Electronically signing will disable further editing.

Applicant or agent's signature: \_\_\_\_\_ Date: \_\_\_\_\_