Markel Insurance Company
P.O. Box 2009, Glen Allen, VA 23058-2009
Telephone: (800) 262-7535 Fax: (804) 527-7784
Email applications to: agapplications@markelcorp.com
Website: horseinsurance.com

PATH INTERNATIONAL
Professional Association of Therapeutic Horsemanship International

PATH International centers – additional insured request form

Markel agent number: _____ Submission or policy number: _____

Effective date of change: _____ Date of request: _____

(The requested effective date must be after the date of receipt of this document and full payment to Markel.)

PATH International center name (applicant):_____

Contact person: _____ Phone: _____ Fax: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Section 1 Additional insured

Name of additional insured: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Section 2 Type of additional insured

Check all that apply. Only one charge applies if party is both horse and premises owner/lessor.

1. Horse owner or lessor: ☐ Private entity - $35 ☐ Governmental entity - $125
2. Premises owner or lessor: ☐ Private entity - $35 ☐ Governmental entity - $125
   a. Indicate location if other than Additional Insured's mailing address: _____
   b. Is this location ☐ **in addition to OR** ☐ **replacement for** current policy location?
      If replacement, indicate location being replaced: _____
      Complete premises supplement if new location for ongoing center's horse operations.
3. Independent contractor working with the center's students and under the direction of the center
   ☐ Independent instructor - $215 ☐ Independent therapist - $215 ☐ Independent clinician - $215
   a. Date of birth: _____ Number of years of experience as instructor/therapist*: _____
      *If less than 5 years, provide narrative on other related experience.
   b. Certification: ☐ None ☐ PATH International ☐ ARIA ☐ CHA ☐ Other: _____

Section 3 Additional insured to be added with respect to: (Check all that apply)

Type of program or event: ☐ Riding instruction program ☐ Public event day* _____

* If public event day, please include dates and submit public event request form.

Total premium enclosed: $_____ (Flat charge – fully earned)

NOTE: This Supplement becomes part of your primary application and must be signed and dated. Coverage cannot be bound until the Company approves your completed application. The Company's receipt of premium does not bind coverage until a written quote has been issued. Before electronically signing this document, verify your information is correct. Electronically signing will disable further editing of your application.

Applicant's signature: _____ Date: _____

Agent's signature: _____ Date: _____

(Florida only) Agent license number: _____