



**INTERCITY
INSURANCE
SERVICES INC.®**

**EQUI-CARE MORTALITY APPLICATION
(One Per Horse)**

15221 Yonge Street, Aurora, ON L4G 1L8
PHONE: (905) 841-8200 FAX: (905) 841-0030 TOLL FREE: 1-888-394-3330

www.intercityinsurance.com

Email: mking@aci.on.ca

Name of Applicant _____
Address _____ City _____ Province _____ PC _____
Phone # (____) _____ Fax # (____) _____ Email _____
Cell # (____) _____ What Provincial Equine Association are you a member of? _____

| | | | |
|-------------------------|-----------------------|---------------------|------------------------------|
| Name of Horse _____ | | | |
| SEX | BREED | COLOUR | YEAR FOALED |
| | | | |
| SIRE | | DAM | |
| | | | |
| DATE OF PURCHASE | PURCHASE PRICE | USE OF HORSE | REGISTRATION/TATTOO # |
| | | | |

Who was horse acquired from? _____

Are you the sole owner? Yes No If NO, state name and address of designated parties and their financial interest (i.e.: Lessor, Syndicate, etc) _____

Are regular inoculations and worming current? Yes No Were there any illnesses or injuries to the above horse within the last 3 years?

Yes No If yes, describe _____

Did any horse die or sustain injury while in your care, custody or control in the last 3 years? Yes No If yes, describe _____

Name/Address/Phone # of individual/stable who cares for this horse _____

Has any insurance company ever cancelled or refused any insurance of any type to you? Yes No If yes, explain _____

Is above horse currently insured? Yes No Insurer: _____ Policy # _____ Expiry _____

Any insurance claims in the last 5 years? Yes No If YES, describe _____

Have you claimed any Veterinary Expenses in the last 3 years? Yes No If YES, describe _____

| COVERAGE | LIMIT | RATE | PREMIUM |
|---|--------------|-------------|----------------|
| Pick one only: <input type="checkbox"/> FULL MORTALITY <input type="checkbox"/> NAMED PERILS | \$ _____ | _____ % | \$ _____ |
| MAJOR MEDICAL / SURGICAL * | \$ 5,000. | FLAT \$200. | \$ _____ |
| MAJOR MEDICAL / SURGICAL * | \$ 10,000. | FLAT \$350. | \$ _____ |
| * Eligibility for Medical Extension is limited to horses insured for Full Mortality & valued at \$5,000 or more. Loss settlement will not exceed Mortality limit. | | | |
| Stallion Infertility <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ _____ | _____ % | \$ _____ |
| World Wide and Air Transit including Berserk <input type="checkbox"/> Yes <input type="checkbox"/> No | \$ _____ | _____ % | \$ _____ |
| TACK & EQUIPMENT (Replacement Cost) | \$ _____ | 3% | \$ _____ |
| TRAILER (Replacement Cost if 10 years or newer): Trailer Make: _____ | \$ _____ | 4% | \$ _____ |
| Model _____ Year _____ S/N _____ | | | |

| | | |
|--|--------------------------------------|----------|
| <u>POLICY SUBJECT TO \$150 MINIMUM & RETAINED PREMIUM</u> | PREMIUM SUB-TOTAL: | \$ _____ |
| | ONTARIO RESIDENTS ADD 8% PST: | \$ _____ |
| | TOTAL POLICY PREMIUM: | \$ _____ |

DECLARATION OF OWNER

I/We understand and agree that the policy to be issued shall be founded upon the statements contained herein; that animals having heaves or vicious habits, that animals which are colickers or emphysematous or bleeders or blind or nerved at or above the fetlock or orphaned foals under 90 days of age are not insurable, that no operation shall be performed on the insured animal without the consent of the company unless the operation is necessary as a result of an insured peril. I/We understand and agree that immediate notice and full details of any lameness, illness, injury or death of the insured animal will be given to the insuring company. I/We agree that this application is the basis of the contract and if anything is falsely stated or information withheld to influence the company's decision, the insurance contract shall be null and void. It is understood that the signing and filing of the application does not bind the company and no insurance shall be effective until this application is accepted by the company based on the information declared.

SIGNATURE OF APPLICANT _____ DATE SIGNED _____ POLICY EFFECTIVE DATE _____
 Visa MasterCard AmEx # _____ Expiry: M _____ Y _____

CARD HOLDER'S NAME (Please Print) _____ CARD HOLDER'S SIGNATURE _____

**** VETERINARIAN CERTIFICATES MUST BE RECEIVED BY INTERCITY INSURANCE WITHIN 30 DAYS OF EXAMINATION ****