



# EQUI-CARE MORTALITY APPLICATION (One Per Horse)

Name of Applicant \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ PC \_\_\_\_\_  
 Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ E-Mail \_\_\_\_\_  
 What Provincial Equine Association are you a member of? \_\_\_\_\_

**NAME OF HORSE (registered/show and barn name)** \_\_\_\_\_

SEX	BREED	COLOUR	YEAR FOALED
DATE OF PURCHASE	PURCHASE PRICE	USE OF HORSE /DISCIPLINE / LEVEL	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 inoculations, dental exam and parasite control current (within last twelve months)?  Yes  No  
 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/individual/stable who cares for this horse \_\_\_\_\_  
 Address/Phone # of individual/stable who cares for this horse \_\_\_\_\_  
 Is above horse currently insured?  Yes  No Insurer: \_\_\_\_\_ Policy # \_\_\_\_\_ Expiry \_\_\_\_\_  
 Any EQUINE insurance claims in the last 5 years?  Yes  No If YES, describe: \_\_\_\_\_  
 Have you ever taken an educational course related to horses?  Yes  No  
 Do you work regularly with a credentialed coach/trainer  Yes  No

COVERAGE	REQUESTED LIMIT	RATE	PREMIUM
Pick one only: <input type="checkbox"/> FULL MORTALITY OR <input type="checkbox"/> NAMED PERILS MORTALITY (includes Death Claim reimbursement, Extra Stabling expense)	\$ _____		\$ _____
<b>Guaranteed Renewal &amp; Agreed Value</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (minimum premium \$50.00)	\$ _____	X 0.50%	\$ _____
<b>MAJOR MEDICAL / SURGICAL</b>	<b>PICK ONE LIMIT</b>		
❖ Claims for Medical / surgical are subject to deductible and / or Co-insurance	<input type="checkbox"/> \$2,500 to \$5,000.	\$225.00	\$ _____
❖ Eligibility for Medical / surgical is limited to horses insured for Full Mortality where the fair market value/limit of coverage is a minimum of \$2,500	<input type="checkbox"/> \$5,001 to 10,000.	\$350.00	\$ _____
❖ Loss settlement for Major Medical/Surgical will not exceed Mortality limit.	<input type="checkbox"/> \$10,001 to 15,000.	\$550.00	\$ _____
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			\$ _____

<b>POLICY SUBJECT TO \$240 MINIMUM &amp; RETAINED PREMIUM</b>	<b>PREMIUM SUB-TOTAL</b>	\$ _____
<b>Premiums are subject to Tax in some Provinces. Please add to premiums as applicable.</b> <b>SK - 6% MB - 7% ON - 8% NL - 15%</b> <b>Policies in BC, AB, NB, NS, NT, YT, PEI are NOT subject to tax.</b>	<b>Provincial Sales Tax as applicable</b>	\$ _____
	<b>TOTAL POLICY PREMIUM</b>	\$ _____

### 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 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 (MM/DD/YYYY) \_\_\_\_\_

*Please call our office to provide credit card details*

**COVERAGE WILL NOT BE EFFECTIVE UNTIL PAYMENT METHOD HAS BEEN CONFIRMED**

**\*\* HEALTH CERTIFICATES MUST BE RECEIVED BY US WITHIN 30 DAYS OF EXAMINATION OR WILL BE CONSIDERED VOID\*\***

**Western Provinces and Territories:**

CapriCMW Insurance Services Ltd.  
 100 - 1500 Hardy Street, Kelowna, BC V1Y 8H2  
**TF** 1 800 670 1877 **F** 1 888 822 6115  
**E** agri@capricmw.ca **W** capricmw.ca/equine

**Ontario and Provinces Eastward:**

CapriCMW Insurance Services Ltd.  
 15221 Yonge Street, Aurora, ON L4G 1L8  
**TF** 1 888 394 3330 **F** 1 888 822 6115  
**E** forms@equicare.ca **W** capricmw.ca/equine