EQUI-CARE DECLARATION OF HEALTH

Capri Insurance Services Ltd.
100-1500 Hardy Street
Kelowna, B.C. V1Y 8H2
Phone (800) 670-1877
Fax (888) 822-6115
Email: agri@capri.ca

Name of Applicant _____

Address _____ City: _____ Province: _____

Postal Code _____ Home # _____ Cell # _____ Fax # _____

Email _____

Previous Policy Number (if applicable) _____ Policy Expiry Date _____

DETAIL OF THE HORSE(S) TO BE INSURED

NOTE: Horse(s) Sex: **M** – Mare **F** – Filly **C** – Colt **S** – Stallion **G** – Gelding

No.	Name of Horse	Year Born	Breed	Sex
1				
2				
3				

Name/Address/Phone # of individual/stable who cares for this horse(s):

_____

Name/Phone Number of Veterinarian:

_____

APPLICANT'S DECLARATION

- I/We warrant and declare that over the last 12 months, there have been no health concerns with the horse (s) described on this form (including, but not limited to injury, lameness, illness, disease, medical attention by a vet, loss of performance or lack/change of use)
  EXCEPT_____
- I/We declare that the Insurer will be **IMMEDIATELY NOTIFIED** if anything occurs within the next twelve (12) months (including but not limited to injury, illness, lameness, disease, medical attention by a vet, loss of performance, or change of use).
- I/We warrant that the horse(s) is/are not receiving and have not received in the last twelve months any **joint injections**
  EXCEPT_____
- I/We warrant that the horse(s) is/are not currently receiving and have not received **any medications** (short or long term) or any preventative treatments in the last twelve months
  EXCEPT_____
- I/We further warrant and declare that the horse(s) described on this form does/do not presently have any condition that could lead to an insurance claim.
- **I/We grant permission to the Insurer to contact my/our Veterinarian for the purpose of verifying the health and/or treatment of the horse(s) described on this form.**

IF THERE HAS BEEN A CHANGE IN THE OVERALL HEALTH OF YOUR HORSE A VET CERTIFICATE MAY BE REQUIRED. THERE WILL BE NO COVERAGE PROVIDED BY THE UPCOMING POLICY TERM FOR MORTALITY AND/OR MEDICAL CLAIMS WHICH ARISE OUT OF OR ARE DUE TO ANY HEALTH CONDITION THAT EXISTED PRIOR TO THE EXPIRY DATE.

SIGNATURE OF APPLICANT: _____ **DATE SIGNED:** _____

****BY SIGNING ABOVE, I/WE AUTHORIZE THE ISSUANCE OF THIS POLICY****

Would you like your policy Mailed via Canada Post ☐ or Emailed ☐