



EQUI-CARE DECLARATION OF HEALTH (One Per Horse)

Name of Applicant _____

Address _____ City _____ Province _____ PC _____

Phone # _____ Cell # _____ E-Mail _____

Previous policy number if applicable: EQUI- _____ Expiry Date: _____

What is your current Provincial Equine Association membership number: _____

NAME OF HORSE (registered/show and barn name) _____

| SEX | BREED | COLOUR | YEAR FOALED |
|---|-------|---|-------------|
| | | | |
| USE OF HORSE /DISCIPLINE / LEVEL | | INSURANCE LIMIT TO BE CONSIDERED (CND FUNDS) | |
| | | \$ | |

- 1) Has the horse ever suffered from any type of colic or digestive tract / gastrointestinal disorder (including ulcers)? YES NO
If YES, please provide details, date of occurrence, treatment and state of recovery:

- 2) Has the horse had a neurectomy (nerved) or fasciotomy? YES NO If YES, date of procedure _____
- 3) Has the horse had any other surgical procedures? YES NO
If YES, please provide description and date of procedure

- 4) Has the horse suffered from any lameness or sickness in the last 12 months? YES NO
If YES, please provide diagnosis, treatments as provided and current status of recovery?

- 5) Is the horse examined annually by a licensed veterinarian for general health and soundness that includes parasite evaluation, dental examination and the administration of recommended vaccinations? YES NO

Date of last full examination: _____ Name of the veterinarian who attended: _____
- 6) Has the horse received any performance or maintenance procedures or treatments, including intramuscular and / or joint injections, any type of medication long or short term, or any preventative treatments in the last twelve months? YES NO
If YES, please provide details _____
- 7) Is the horse normal in heart, respiration, vision and movement without medication? YES NO
If NO, please provide details _____
- 8) To your knowledge has the horse been exposed to any contagious or infectious disease in the last 12 Months? YES NO
If YES, please provide details _____

DECLARATION OF OWNER

To the best of my knowledge, I DECLARE that the above information is true and that there is no other information that should be brought to the attention of the insurer. I understand that any misrepresentation of a material fact related to this insurance will adversely affect coverage provided. I further DECLARE that I will immediately advise the insurer of any change in the health or soundness of the horse.

SIGNATURE OF HORSE OWNER/POLICY HOLDER DATE SIGNED

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