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:

Acera 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:

Acera 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