

# RENEWAL APPLICATION

**Ogden Insurance Agency, Inc.**

**P.O. Box 230  
Petersburg, IL 62675**

**800-502-8995**

**Fax: 217-632-2216**

**email - dave@ogdeninsurance.com**

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Name and Address of Owner: \_\_\_\_\_

Business Telephone: (     ) \_\_\_\_\_

Home Telephone: (     ) \_\_\_\_\_

Fax Telephone: (     ) \_\_\_\_\_

Broker's Name: \_\_\_\_\_

Last Year's Policy Number: \_\_\_\_\_

◆ Desired Effective Date: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Horse	Breed	Sex*	Exact Use	Level	Date of Birth	Purchase Date	Purchase Price	Insured Amount**†
A.								
B.								
C.								
D.								

\*G-Gelding, M-Mare, S-Stallion

\*\* If requested value exceeds the purchase price, please provide explanation of value (i.e. competition record, appraisal, training, etc.)  
† Insured amount should not exceed the horse's current fair market value.

Loss Payee or Additional Insured Name: \_\_\_\_\_

(Please indicate on which horses Loss Payee or Additional Insured Name applies.)

1. Is the horse(s) currently sound and healthy for the use intended? Yes  No
2. For all Quarter Horses, Appaloosas, or Paint horses.  
Does any horse have an ancestor known to carry HYPP? Please indicate "Yes" or "No" for each horse.  
If "Yes" is answered for any horse, please indicate the HYPP status (N/N, N/H, H/H) for each horse.  
(Note: Coverage will not be considered without the disclosure of HYPP status.)
3. Does the horse(s) have any past or present conformation problems, defects or ailments, illness or disease, lameness, injury or physical disability including but not limited to: laminitis/founder, OCD, neurological disorders, navicular disease, and/or degenerative joint disease? Yes  No
4. Has the horse(s) had any colic or intestinal disorder within the last 36 months? Yes  No
5. Has the horse(s) been nerved or received any surgical treatment for lameness? Yes  No
6. Has the horse(s) been examined or treated by a veterinarian for anything **other** than routine care within the last year? Yes  No
7. Has the horse(s) undergone diagnostic ultrasounds, X-rays, or bone scans within the last 36 months? Yes  No
8. Has the horse(s) received any joint injections in the last 12 months? If yes, please specify joints injected, dates and reasons for injections below. Yes  No
9. Has the horse(s) received any type of medication long or short term, or any preventative treatments in the last 12 months? Yes  No
10. Does the horse(s) receive any other medications/supplements? Yes  No
11. Are there any other current or prior health conditions to which the horse(s) has been exposed? Yes  No
12. Will any horse be outside the continental United States or Canada during the coverage period? Yes  No

If the answer to question 1 is "No" for any horse, please indicate the horse and provide details below. If "Yes" was answered to any question 3 through 11, please indicate the horse and provide details below. Include onset date, diagnosis, treatment, how condition resolved, and when the horse returned to full work. For question 12, provide details including dates and locations for coverage consideration.

**Please attach updated information on the horse(s) show/competition record, training, or breeding information.**

I understand and agree that the policy to be issued shall be founded upon the statements contained herein and prior policy information and this statement shall be the basis of the contract and if anything be falsely stated, or information withheld, to influence the Company's decision, the insurance shall be null and void.

Signature of owner (s) of above named animal \_\_\_\_\_

Date: \_\_\_\_\_  
(must be no more than 30 days prior to policy effective date)

**Specify the Mortality Coverage Desired**

(select one or the other for each horse)

- |               |                          |                          |                          |                          |   |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <b>Horse:</b> | <b>A</b>                 | <b>B</b>                 | <b>C</b>                 | <b>D</b>                 |   |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Full Mortality Coverage (Standard Full mortality coverage includes Colic Surgery, Guaranteed Extension, and Value coverages.) |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Named Perils Coverage   |

**Additional Coverages Available to horses covered for Full Mortality**

- |               |                          |                          |                          |                          |  |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <b>Horse:</b> | <b>A</b>                 | <b>B</b>                 | <b>C</b>                 | <b>D</b>                 |  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Major Medical and Surgical (annual limit \$7,500, not to exceed the horse's insured mortality limit) – PREMIUM IS FULLY EARNED |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Major Medical and Surgical (annual limit \$10,000) – PREMIUM IS FULLY EARNED   |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Surgical Only – PREMIUM IS FULLY EARNED  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Colic Medical and Surgical – PREMIUM IS FULLY EARNED   |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Full Loss of Use (Plan A)  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | External Injury Only Loss of Use (Plan B)  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stallion Infertility for A, S & D  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Third Party Liability  |
|               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Territorial Limits, Including International Transit (Must complete question 23 above) – PREMIUM IS FULLY EARNED                |