



# Markel Insurance Company

P.O. Box 2009, Glen Allen, VA 23058-2009

Telephone: (800) 446-7925 (804) 965-1698 Fax: (804) 527-7999

Email applications to: agapplications@markelcorp.com

Website: horseinsurance.com

## Veterinary certificate of examination

Markel agent number: \_\_\_\_\_ Submission or policy number: \_\_\_\_\_

Named insured: \_\_\_\_\_

Horse name & tattoo or reg. no.	Breed	Age	Color	Sex	Sire/Dam

Owned by, if other than insured: \_\_\_\_\_ Location of animal(s): \_\_\_\_\_

The horse being examined should be moved about outside of the stall to demonstrate soundness of limb and freedom of movement. Careful observation should be made as to housing conditions and the presence of contagious disease.

**Please request additional form for permanent disability coverage.**

**TO THE VETERINARIAN:** Horses with a history of colic, founder or nerving may not be insurable. If there is evidence or knowledge of these problems, please provide all details. I, \_\_\_\_\_, **do certify that I am a graduate Veterinarian holding a current license to practice in \_\_\_\_\_ (indicate state).** **Are you the usual Veterinarian?**  Yes  No

1. Pulse & respiration normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Has a complete pre-purchase or soundness exam been performed within the past 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Temperature normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Provide details of any abnormal results.</b>
3. Eyes clinically normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. To your knowledge, have any of these horses suffered an accident, sickness or disease, had any veterinary treatment (apart from preventive inoculations) or have been unsound in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Heart auscultated & found normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, provide details on separate sheet.</b>
5. History or evidence of bleeder? <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Subject to or any history of gastro intestinal/digestive disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. History or evidence of nerving? <input type="checkbox"/> Yes <input type="checkbox"/> No	24. a. Has any surgery been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Ever been treated for navicular disease, arthritis, laminitis or founder? <input type="checkbox"/> Yes <input type="checkbox"/> No	b. If yes, has horse fully recovered? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Any indication or history of lameness and/or faulty conformation? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, provide details on separate sheet.</b>
9. Any diagnostic procedures, include ultrasounds, x-rays, bone scans, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Is there likelihood of future danger to life or limb as a result of such surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are any preventive treatment(s)/supplements used including, intramuscular and/or intravenous? <input type="checkbox"/> Yes <input type="checkbox"/> No	26. If male, are both testicles evident? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give details: _____	27. Has horse been castrated? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are any intra-articular injections used? <input type="checkbox"/> Yes <input type="checkbox"/> No	28. a. If female, is she reported in foal? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, give details: _____	b. If in foal, give date due: _____
12. Evidence of firing or blistering? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>For foals 24 hours to 90 days of age, complete the following questions:</b>
13. Any conditions detrimental to satisfactory breeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	29. Was birth normal with no complications? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Ever been tested/treated for EPM? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, provide details on separate sheet.
If yes, Date: _____ Results: _____	30. Date and time of birth: _____
15. Any episodes related to HYPP? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Normal urination and bowel movement? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Any indication of infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	32. Has foal received any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. Contagious disease on premises or in neighborhood? <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Is IgG/CBC normal on this date? <input type="checkbox"/> Yes <input type="checkbox"/> No
18. Any clinical evidence of objectionable vices or habits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Is the stabling and/or fencing adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Have you discussed the horse's health history with the owner or caretaker? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Give complete details in regard to any the above questions that might have a bearing on the health or conformation or soundness of this horse: \_\_\_\_\_

Are any of these horses receiving any medication? If so, give details: \_\_\_\_\_

In addition, are there any other medical facts that you feel should be brought to the attention of the Company? \_\_\_\_\_

**Except as noted above, I certify that to the best of my knowledge & belief the horse is healthy & insurable sound.**

Signature: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_ Fax number: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Date & time of exam: \_\_\_\_\_

**This certificate must be received by the Company within 30 days of the exam date and/or prior to renewal.**

**Please note the owner/agent is responsible for submitting this form to the Insurance Company.**

**NOTE:** This Certificate becomes part of your primary application and must be signed and dated. Coverage cannot be bound until the Company approves your completed application. The Company's receipt of premium does not bind coverage until a written quote has been issued.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's signature: \_\_\_\_\_ (Florida only) Agent license number \_\_\_\_\_ Date: \_\_\_\_\_