



NEW BUSINESS /
ENDORSEMENT APPLICATION

701 Rock Island Ave.
Dalhart, TX 79022

940-241-9730
info@coveredbycori.com

CARRIER: _____

SUB-AGENT: _____

PREMIUM: _____

PAY PLAN: _____

IMPORTANT :

This policy does NOT include Burial or Necropsy Expenses for horses. Please check one box to either accept or decline the coverage.

- ☐ I/We decline coverage for burial and necropsy expenses for our horses.
☐ I/We would like to include coverage for burial and necropsy expenses for our horses.

(Additional \$150/ Annually)

(Additional \$164 Annually in FL)

PAYMENT METHOD: ☐ Check ☐ Payment Link ☐ Credit Card

Credit Card Number _____ Expiration Date _____ Sec Code. _____

NAME OF OWNER(S): _____ EFF. DATE: _____

ADDRESS OF OWNER(S): _____

CITY/STATE/ZIP: _____

EMAIL: _____ PHONE: _____

NAME OF HORSE	SEX	BREED	DOB	MONTH AND YEAR OF PURCHASE	USE	PURCHASE PRICE	INSURANCE AMOUNT DESIRED	MAJOR MEDICAL
A.								
B.								
C.								
D.								
E.								
F.								

1. Are you the sole owner of the above horse(s)? ☐ YES ☐ NO
2. Has any insurance company ever cancelled any insurance or refused to insure an animal(s) in which you had an insurable interest? ☐ YES ☐ NO
3. Are any of the above horse(s) currently insured? ☐ YES ☐ NO
4. Was a pre purchase exam completed on this horse(s)? ☐ YES ☐ NO
5. Is the horse currently sound and healthy for use intended? ☐ YES ☐ NO
6. Have any of the above horse(s) been tested for HYPP? ☐ YES ☐ NO
If "yes" is answered, please indicate the HYPP status. ☐ N/N ☐ N/H ☐ H/H
7. Has the horse had any colic or intestinal disorder within the last 36 months? ☐ YES ☐ NO
8. Does the horse have any past or present conformation problems, defects or ailments, illness or disease, lameness, injury or physical disability including but not limited to lameness, founder, OCD, or Neurological issues. ☐ YES ☐ NO
9. Has the horse been nerved or received any joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? ☐ YES ☐ NO
10. Will this horse be stalled at a training facility? If so, what is the name and contact information of the trainer?

IF "YES" WAS ANSWERED TO ANY QUESTIONS 5-9, PLEASE PROVIDE DETAILS BELOW. INCLUDE ONSET DATE, DIAGNOSIS, TREATMENT, HOW CONDITION RESOLVED, AND WHEN THE HORSE RETURNED TO FULL WORK.

I/WE, THE UNDERSIGNED, HEREBY APPLY TO INSURE THE ABOVE-MENTIONED ANIMALS OWNED BY ME, SUBJECT TO THE TERMS AND CONDITIONS OF THE POLICY TO BE ISSUED, AND I DECLARE TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE AND THAT I HAVE NOT WITHHELD ANY MATERIAL INFORMATION. SIGNING THIS FORM DOES NOT BIND THE APPLICANT TO COMPLETE THE INSURANCE BUT IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IF ANYTHING BE FALSLEY STATED OR INFORMATION WITHHELD TO INFLUENCE THE COMPANY'S DECISION, THE INSURANCE CONTRACT WILL BE NULL AND VOID.

I/WE UNDERSTAND THAT IMMEDIATE NOTICE MUST BE GIVEN TO THE COMPANY UPON ANY INJURY, ILLNESS, OPERATION, DISEASE, OR DEATH OF AN INSURED HORSE.

SIGNATURE OF OWNER(S) OF ABOVE NAMED ANIMAL(S)

DATE OF SIGNATURE

JUSTIFICATION OF VALUE ON ANY OF THE ABOVE HORSES THAT REQUESTED AMOUNT OF INSURANCE IS MORE THAN THE PURCHASE PRICE.

HORSE:

Show Accomplishments:

Money Earned:

Current Standings:

Training:

HORSE:

Show Accomplishments:

Money Earned:

Current Standings:

Training:

HORSE:

Show Accomplishments:

Money Earned:

Current Standings:

Training:

HORSE:

Show Accomplishments:

Money Earned:

Current Standings:

Training:

HORSE:

Show Accomplishments:

Money Earned:

Current Standings:

Training: