

COPY OF THE NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT.

(Not applicable in all states, consult your agent or broker for your state's requirements.)

NOTICE OF INSURANCE INFORMATION PRACTICES - PERSONAL INFORMATION ABOUT YOU MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS, IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

IN FLORIDA, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

IN KANSAS, ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE COMMITTING A FRAUDULENT INSURANCE ACT, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE ENQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

APPLICANTS SIGNATURE

DATE (Must be no more than 30 days prior to policy effective date)

PRODUCERS SIGNATURE

PRODUCERS NAME (Please Print)

STATE PRODUCER LICENSE NO.
(Required in Florida)



Butch Human, Manager
P.O. Box 2250
Advance, NC 27006
info@starhinsurance.com

VETERINARIAN'S STATEMENT OF EXAMINATION
For Horses



Producer's Name _____	Applicant's Name _____
Agency Code _____	Mail Address _____
Mail Address _____	City, ST Zip _____
City, ST Zip _____	Phone _____
Phone _____	Fax _____
Fax _____	E-Mail Address _____
E-mail Address _____	

Horse Name: _____ **Date of Birth:** _____ **Sex:** _____ **Use:** _____

For Quarter Horses, Appaloosas, or Paints that have an ancestor known to carry HYPP, please indicate the horse's HYPP status (check one.) N/N N/H H/H N/A
Has the horse experienced any HYPP signs or symptoms? Yes No If Yes, please explain:

Pulse and Respiration normal at rest and after work? <input type="checkbox"/> Yes <input type="checkbox"/> No Heart auscultation normal at rest and after work? <input type="checkbox"/> Yes <input type="checkbox"/> No Respiration auscultation normal at rest and after work? <input type="checkbox"/> Yes <input type="checkbox"/> No Temperature normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Eyes clinically normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations normal? Back <input type="checkbox"/> Yes <input type="checkbox"/> No Stifles <input type="checkbox"/> Yes <input type="checkbox"/> No Knees <input type="checkbox"/> Yes <input type="checkbox"/> No Hocks <input type="checkbox"/> Yes <input type="checkbox"/> No Fetlocks <input type="checkbox"/> Yes <input type="checkbox"/> No Tendons and Ligaments <input type="checkbox"/> Yes <input type="checkbox"/> No (Please note any swelling, heat, stiffness and/or pain for any answer "No".) Hoof tester results negative? <input type="checkbox"/> Yes <input type="checkbox"/> No Properly shod? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the stabling and turn out safe and adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No If any are answered no, please explain on a separate page	Has the horse ever had colic surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No Subject to or any previous history of colic? <input type="checkbox"/> Yes <input type="checkbox"/> No History or evidence of a bleeder? <input type="checkbox"/> Yes <input type="checkbox"/> No History or evidence of nerving? <input type="checkbox"/> Yes <input type="checkbox"/> No Any evidence or history of laminitis, club foot, or P3 rotation? <input type="checkbox"/> Yes <input type="checkbox"/> No Any evidence of infection or disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Contagious diseases on premises or locally? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there evidence of objectionable habits? Vices? <input type="checkbox"/> Yes <input type="checkbox"/> No Any history of uncharacteristic behavior in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Any major conformation faults, which may affect the horse for its intended use, short or long term? <input type="checkbox"/> Yes <input type="checkbox"/> No Any evidence of lameness jogging straight or on circles in both directions? <input type="checkbox"/> Yes <input type="checkbox"/> No Any evidence of bone or joint disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the horse subject to chronic metritis and/or mastitis? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the horse pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give expected date of birth: _____ If the horse is a breeding horse, to your knowledge is there any history of gestation, lactation or parturition problems? . <input type="checkbox"/> Yes <input type="checkbox"/> No If any are answered yes, please explain on a separate page.
Are you the usual veterinarian for the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, have you treated/examined this horse previously? Explain: _____	

Are you aware if the horse has received any performance enhancing procedures, including intramuscular and/or joint injections, any type of medication long or short term, or any preventative treatments in the last 12 months? Yes No
Have you or any other veterinarians attended the horse for any ailment, injury, lameness, or medical problem in the last 12 months? Yes No
Has the horse ever undergone surgery? Yes No
Are you aware of any condition, past or present that could require surgical or medical attention in the next 12 months? Yes No
Are you aware of any history of unsoundness, injury or disease on this horse? Yes No
Other findings or remarks? _____
Provide details of any degenerative changes, bone spurs, chips or osteochondrosis seen on any radiographs taken.
If any are answered yes, please explain on a separate page.

If Loss of Use Coverage is being requested, please complete the following:
X-rays: Must be current within 30 days. Please list below all radiographic findings, especially those that may affect the horse's long term and short-term intended use. If possible, use any previous X-rays for comparisons, i.e. navicular. All views listed below are required for Full Loss of Use coverage. If additional views were taken, please describe results. Use a separate page if necessary. **Note NSF and WNL are not acceptable descriptions for findings.**
Front Feet - Lateromedial, dorsal ventral, navicular skyline:
Front Fetlocks - A/P views:
Hind Fetlocks - A/P views:
Hocks - Lateral projection, craniocaudal projection, both oblique:
Stifles - Lateromedial views:
Give your general evaluation for the above named horse, and your professional opinion on soundness, both short and long term, for its intended use.

Veterinarian's Signature

Date

Telephone Number

Veterinarian's Address: _____

