



THE EQUESTRIAN GROUP

A division of Allen Financial Insurance Group

EQUINE ANIMAL SERVICES APPLICATION

Date:

Renewal of #

Agency Name:	Program Administrator: Allen Financial Insurance Group	Direct 800-874-9191 FAX 602-992-8327
Producer Name:	<input type="checkbox"/> Commercial General Liability	
Producer Email:	<input type="checkbox"/> Commercial Property	
Producer Phone:		
Effective Date:	Expiration Date:	Quote Desired By:

Name of Applicant:

Mailing Address:

City, State, Zip:

<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> LLC	<input type="checkbox"/> Corporation	<input type="checkbox"/> Not For Profit
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Inspection Contact:	Email:
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Telephone # (Required):	Website:
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Social Security / Federal Tax ID:

Method of Payment: <input type="checkbox"/> Agency Bill	Payments: <input type="checkbox"/> Annual
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Type of Activities Offered (Check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Equine Hydrotherapy | <input type="checkbox"/> Equine Massage | <input type="checkbox"/> Equine PEMF | <input type="checkbox"/> Farrier Services |
| <input type="checkbox"/> Equine Grooming | <input type="checkbox"/> Equine Laser Therapy | <input type="checkbox"/> Acuscope / Myopulse | <input type="checkbox"/> Saddle Fitting |
| <input type="checkbox"/> Equine Security Services | | | |

Other Services

Industry Affiliations & Accreditations? ☐ Yes ☐ No
Name of Organization

If multiple services are performed please include an annual gross receipt breakdown by activity.

How long has the applicant been in this field?	Gross receipts? \$
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Is this new business to your agency? Yes No	How long have you known the applicant?
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I/We understand and agree that any misstatement of warranty or fact on this application shall be considered a violation of coverage afforded under any policy issued on the basis of this application. The insured assigns as security for the total premium and/or fees payable any and all unearned premiums which may become payable. I/We agree to pay reasonable attorneys fees, costs and expenses necessarily incurred if suit or collection becomes necessary.

Applicant's signature:	Agent's signature:
Date:	Date:

Allen Financial Insurance Group
13880 N Northsight Blvd Ste C109 Scottsdale, AZ 85260 602.992.1570 FAX 602.992.8327
Email: agribusiness@egggroup.com Website: www.amriskusa.com

AMR-AS-103023

OPERATIONS OVERVIEW

Additional Premises Operations? (Check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Farming Operations | <input type="checkbox"/> Farm "Pick Your Own" sal | <input type="checkbox"/> Retail Sales | <input type="checkbox"/> Boarding - Training |
| <input type="checkbox"/> Riding Instruction | <input type="checkbox"/> RV Hookups / Campsites | <input type="checkbox"/> Kennels | <input type="checkbox"/> Wagon Rides |
| <input type="checkbox"/> Day or Overnight Camps | <input type="checkbox"/> Special Events | <input type="checkbox"/> Pony Ride / Petting Zoo | <input type="checkbox"/> Trail Rides |
| <input type="checkbox"/> Other | | | |

Does the Applicant operate any type of "At Risk" program defined as persons involved in a program as a result of and local, state, federal government or court mandated program including but not limited to criminal rehabilitation or community service sentencing. ☐ Yes ☐ No

If Yes, provide details including copy of agreement with assigning agency.

Number of employees: Full time _____ Part time _____ Annual payroll \$ _____

Does the Applicant carry Workmen's Compensation insurance? ☐ Yes ☐ No

Licensed by ***

Attach copy of state or governmental licenses

If Yes, has your license ever been suspended or revoked? ☐ Yes ☐ No If Yes, include explanation.

Is this program part of any school curriculum, recreational center or in any way associated with a city, county or state program? ☐ Yes ☐ No

If YES Please explain

Is there 24 hour supervision of facility ☐ ☐ ☐ Yes ☐ No

If No explain

Does the Applicant use any unlicensed motorized vehicles i.e. Golf Carts, ATV, Scooters, etc? ☐ Yes ☐ No

Use of any vehicle is limited to Applicant and Employees only.

Do you provide transportation to and from the facility? ☐ Yes ☐ No

If YES Please explain

Do you have a written and enforced Smoking Policy? ☐ Yes ☐ No

Are "no smoking" signs posted in areas not designated for smoking? ☐ Yes ☐ No

Does the Applicant have any exchange labor working for the Facility? ☐ Yes ☐ No

If YES explain

Bodily Injury to any person arising out of and in the course of a person acting on the behalf of the named insured, whether through employment, voluntary or otherwise is not covered by general liability in this policy. Coverage for bodily injury to employees is provided for in accident medical coverage and workman's compensation coverage.

Has any staff member had any history of violence or criminal behavior? ☐ Yes ☐ No

Funding sources: Check all that apply

☐ Client Fees ☐ Federal ☐ State ☐ County ☐ Donations ☐ Other

Annual operating budget: \$ Annual Gross Receipts: \$

COMMERCIAL LIABILITY SECTION

Coverage	Limits of Liability			
Bodily Injury and Property Damage Liability	\$ 1,000,000	Each "Occurrence" Limit		
	\$ 2,000,000	General Aggregate Limit		
Personal and Advertising Injury Liability	\$ 1,000,000	Each "Occurrence" Limit		
	\$ 2,000,000	General Aggregate Limit		
Medical Payments	\$ 5,000	Any One Person Limit		
	\$ 25,000	Each "Occurrence" Limit		
Damage to Property of Others	\$ 100,000			
Excess Liability Limit	\$			
Equine Commercial Liability? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Property / Farm Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Complete ACORD / Farm application	Automobile Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD automobile application			
Excess Liability Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Submit ACORD application				
ADDITIONAL INTERESTS	Affiliated or subsidiary companies to be insured	Relationship		
	Additional Insureds	Interest	Sec.I	Sec.II
	Additional Insureds	Interest	Sec.I	Sec.II

RELEASES / WAIVERS / PROFESSIONAL LIABILITY

Submit the following if applicable to your operation :

- ☐ Liability release form being used
- ☐ Client Hold Harmless / Liability Release
- ☐ Volunteer Hold Harmless / Liability Release
- ☐ Professional liability insurance certificate
- ☐ Employee / Volunteer handbook, rules, guidelines, safety training

MANAGEMENT PRACTICES

1.	Is the staff required to report all incidences that may result in a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are written records of all incidences kept by the administrator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are all incidences reviewed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Do you have a formal written safety program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Do have a written emergency plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you or your staff trained in first aid procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are assistants trained in your procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Describe types of restraint methods used while performing services.	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> Handler <input type="checkbox"/> Cross Ties <input type="checkbox"/> Other	
10.	Do you have sign in/sign out procedures for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Staff <input type="checkbox"/> Clients <input type="checkbox"/> Visitors / Public	

Loc. #	Sec.I	Sec.II	Locations to be Insured (Include County and Zip Code)	# of Acres	Check if NO Buildings	Insured's Interest		
						Owner Occupant	Lessee	Mobile
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PRIOR CARRIER INFORMATION				
Line	Category	Year	Year	Year
LIABILITY	Carrier	•		
	Policy No.			
	Policy Type			
	BI/CSL			
	Total Premium	•		

LOSS HISTORY <input type="checkbox"/> Check here if none						
Enter all claims or occurrences that may give rise to claims for 5 years						
Date of Occurrence	Line	Type/Description of Occurrence or Claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed
						<input type="checkbox"/> Open
						<input type="checkbox"/> Closed

Has any policy been cancelled? ☐ Yes ☐ No Non-renewed? ☐ Yes ☐ No Declined? ☐ Yes ☐ No

Have you ever contributed to a claim or accident or found negligent in any past equine activity? ☐ Yes ☐ No
Explain yes answers:

EMPLOYEE / VOLUNTEER EXPERIENCE

List all personnel including instructors, employees, therapists, volunteers and trainees

Names of W2 employees / volunteers to be insured under this policy.	License – Certification - Experience	Owner, Partner Or Officer ?	W2 Employee or Volunteer ?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
*For any Paraprofessionals (unlicensed or uncertified please indicate job title and duties			

Notes & Comments:

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APPLICATION FOR LEGAL LIABILITY OF NONOWNED HORSES IN YOUR CARE, CUSTODY OR CONTROL

AGENCY NAME		
ADDRESS		
TELEPHONE	FAX	AGENCY CODE

THIS IS NOT A BINDER

☐ DIRECT BILL
 ☐ NEW BUSINESS – DESIRED EFFECTIVE DATE ____/____/____
☐ ACCOUNT CURRENT
 ☐ RENEWAL – EXPIRATION DATE ____/____/____
 ☐ POLICY NO. CCC_____

IMPORTANT: INCOMPLETE AND UNSIGNED APPLICATION WILL BE RETURNED FOR COMPLETION.

NAME OF INSURED	BUSINESS/STABLE NAME
MAILING ADDRESS	
CITY/STATE/ZIP CODE	TELEPHONE NO.
LOCATION OF ACTUAL OPERATIONS IF OTHER THAN MAILING ADDRESS	
COUNTY	CITY/STATE/ZIP CODE
IF CORPORATION, LIST ALL OFFICERS AND DIRECTORS. IF PARTNERSHIP, LIST ALL PARTNERS	

A SEPARATE APPLICATION FOR THE INFORMATION THAT FOLLOWS WILL BE REQUIRED FOR EACH LOCATION.

DO YOU: <input type="checkbox"/> OWN <input type="checkbox"/> LEASE <input type="checkbox"/> RENT THE PREMISES?	HOW LONG HAS INSURED OR MANAGER BEEN IN THIS BUSINESS? _____ YEARS. IF LESS THAN THREE YEARS, BRIEFLY DESCRIBE RELATED EXPERIENCE. _____ _____ _____
IF LEASED/RENTED, WHO IS RESPONSIBLE FOR FENCE REPAIR? _____ IF LEASED/RENTED, WHO IS RESPONSIBLE FOR BUILDING REPAIR? _____ DESCRIBE TYPE OF FENCING USED IN RUNS, PASTURES, PADDOCKS: _____ DESCRIBE CONDITION OF FENCES: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR DESCRIBE CONDITION OF STABLES: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR OPERATIONS: <input type="checkbox"/> STABLE OWNER <input type="checkbox"/> BOARDING <input type="checkbox"/> BREEDING <input type="checkbox"/> TRAINING <input type="checkbox"/> OTHER	
BREED OF ANIMALS _____ USE OF ANIMALS _____ DESCRIBE TYPE OF SECURITY/SUPERVISION OF STABLES _____	
ARE FIRE EXTINGUISHERS ACCESSIBLE AND OPERABLE IN EACH STABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO IS ANY STABLE OVER 25 YEARS OLD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN WAS THE LAST TIME ELECTRICAL WIRING WAS CHECKED, CERTIFIED SAFE, AND SUITABLE FOR CURRENT USAGE? _____	

CARE, CUSTODY OR CONTROL

NUMBER OF STALLS: BARN #1 _____ BARN #2 _____ BARN #3 _____ BARN #4 _____

MIN # OF NON-OWNED HORSES IN YOUR CARE _____ MIN VALUE OF NON-OWNED HORSES IN YOUR CARE _____

AVG # OF NON-OWNED HORSES IN YOUR CARE _____ AVG VALUE OF NON-OWNED HORSES IN YOUR CARE _____

MAX # OF NON-OWNED HORSES IN YOUR CARE _____ MAX VALUE OF NON-OWNED HORSES IN YOUR CARE _____

POLICY COVERAGE INCIDENTAL TRANSPORTATION ONLY, UP TO 150 MILES FROM INSURED'S LOCATION.
*COVERAGE MAY BE EXTENDED. REFER TO UNDERWRITER FOR PREMIUM.

DO YOU TRANSPORT HORSES FOR OTHERS? ☐ YES ☐ NO IF YES, MAXIMUM NUMBER OF TRIPS PER YEAR _____

MAXIMUM NUMBER OF ANIMALS PER TRIP _____ RADIUS OF NORMAL OPERATIONS _____ miles

NUMBER OF TRIPS AND DESTINATIONS EXCEEDING NORMAL 150 MILE RADIUS _____

HOW OFTEN ARE TRAILER OR VAN FLOOR BOARDS CHECKED _____

ARE FIRE EXTINGUISHERS CARRIED ON VAN OR TRUCK? ☐ YES ☐ NO

DO AT LEAST TWO PEOPLE GO ON EACH TRIP? ☐ YES ☐ NO

DESCRIBE ANY LOSSES OR POTENTIAL CLAIMS IN THE PAST THREE YEARS AND INCLUDE DEATHS OF ANY ANIMAL(S) IN YOUR CUSTODY, EVEN IF A CLAIM WAS NOT PRESENTED _____

FRAUD NOTICES

Standard: Any person who knowingly and with intent to defraud any insurance company of other person files an application for insurance or statement of claim continuing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and may subject such person to criminal and civil penalties.

Florida Applicants: 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.

New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICANT (PRINT)

SIGNATURE

X

DATE

/ /

AGENT SIGNATURE


X

DATE

/ /

I understand that the insurance being applied for, if accepted by the Company, will be based on the statements made in this application. If information is withheld or falsely stated, any insurance issued may be subject to rescission or modification as provided by the law of the state in which the application was accepted or the policy issued.

**CARE CUSTODY OR CONTROL PROGRAM
LIMITS OF LIABILITY (CHECK ONE)**

	Limit Per Horse	Limit Per Occurrence	Annual Aggregate	Premium to 8 Horses	Additional Charge per Horse
<input type="checkbox"/>	\$5,000	\$25,000	\$25,000	\$150	\$8
<input type="checkbox"/>	\$10,000	\$50,000	\$50,000	\$225	\$11
<input type="checkbox"/>	\$10,000	\$100,000	\$100,000	\$250	\$13
<input type="checkbox"/>	\$15,000	\$150,000	\$150,000	\$300	\$18
<input type="checkbox"/>	\$25,000	\$250,000	\$250,000	\$350	\$21
<input type="checkbox"/>	\$50,000	\$250,000	\$250,000	\$550	\$21
<input type="checkbox"/>	\$100,000	\$300,000	\$300,000	\$700	\$23
<input type="checkbox"/>	\$150,000	\$400,000	\$400,000	\$1,050	\$24
<input type="checkbox"/>	\$200,000	\$400,000	\$400,000	\$1,150	\$25

Some limit options not available in all states
Limits over 100,000/300,000 must be referred to the company for approval

Allen Financial Insurance Group
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