



# The Equestrian Group

Allen Financial Insurance Group

Date  
 Producer:

## EQUINE DENTISTRY INSURANCE APPLICATION

**IMPORTANT: This coverage is intended to insure liability arising out of applicant's commercial equine dentistry operations only.**

**ALL OPERATIONS MUST BE DECLARED**

NEW BUSINESS – DESIRED EFFECTIVE DATE \_\_\_ / \_\_\_ / \_\_\_

NAME OF APPLICANT	BUSINESS NAME
MAILING ADDRESS / CITY / STATE / COUNTY / ZIP CODE	
TELEPHONE NUMBER ( )	PERSON TO CONTACT FOR INSPECTION
FAX NUMBER ( )	EMAIL ADDRESS
WEBSITE	FEIN or SSAN
YEAR BUSINESS ESTABLISHED	

**TYPE OF OPERATION** Check all that apply

If any of the operations listed below are being conducted by the applicant, complete a Commercial Equine Liability application and appropriate supplement(s) located on our website at [www.eqgroup.com](http://www.eqgroup.com).

- |                                                    |                                   |                                              |                                               |
|----------------------------------------------------|-----------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Boarding                  | <input type="checkbox"/> Training | <input type="checkbox"/> Breeding / Sales    | <input type="checkbox"/> Hay / Carriage Rides |
| <input type="checkbox"/> Riding Instruction        | <input type="checkbox"/> Rodeo    | <input type="checkbox"/> Horse Show          | <input type="checkbox"/> Pony Rides           |
| <input type="checkbox"/> Equipment / Product Sales | <input type="checkbox"/> Racing   | <input type="checkbox"/> Veterinary Services | <input type="checkbox"/> Other                |

LOCATION(S) OF ACTUAL OPERATIONS – INDICATE IF APPLICANT OWNS OR LEASES PREMISES

Address (including County & Zip Code) \_\_\_\_\_ Number of Acres \_\_\_\_\_ Premises \_\_\_\_\_

1. \_\_\_\_\_  Own  Lease

APPLICANT IS

Individual     Partnership     LLC / Corporation     Owner Operator     Tenant

NAME OF ALL PARTNERS OR OFFICERS OF CORPORATION

**LIMITS OF LIABILITY – PLEASE CHECK ONLY ONE SET OF DESIRED LIMITS**

\$1,000,000 CSL/Occ.     \$500,000 CSL/Occ.     Include Equine Professional Liability  
 \$2,000,000 Agg.     \$1,000,000 Agg.

**COVERAGE FOR CARE, CUSTODY, OR CONTROL FOR NON-OWNED HORSES:**     YES Please quote this coverage

\$5,000 / \$25,000     \$10,000 / \$50,000     \$25,000 / \$250,000     \$50,000 / \$250,000     \$100,000 / \$300,000

Care, Custody & Control/Legal Liability provides coverage arising from applicant's negligence resulting in injury to or death of horses applicant does not own in the applicant's care, custody and control as a result of the applicant's negligence as an equine dentist. Coverage includes cost to defend any suit alleging injury or death. This cannot be restricted by contractual or hold harmless agreements. Settlements are based on actual cash value at time of loss. Please read wording in policy coverage form.

**COVERAGE FOR OWNED TRANSPORTABLE EQUIPMENT**     YES Please quote this coverage

\$1000 Deducible per claim    Limit of Coverage: \$ \_\_\_\_\_    Attach schedule of equipment over \$1,500 per item

# EQUINE DENTISTRY SERVICES INFORMATION

1. Does applicant service animals other than horses?  Yes  No  
 If yes, what type of animals:

a. Number of years of experience as an equine dentist: \_\_\_\_\_

Did the applicant attend dentistry school?  Yes  No

Name of school: \_\_\_\_\_

Does applicant hold a certification?  Yes  No

What association? \_\_\_\_\_

Does applicant hold a veterinarian license?  Yes  No

How long? \_\_\_\_\_

Is applicant a member of:  Yes  No Association Name \_\_\_\_\_

Average number of horses applicant works on each year: \_\_\_\_\_ (Count each horse only once.)

<b>PAYROLL FOR DENTISTRY OPERATIONS</b>	<b>GROSS RECEIPTS FOR DENTISTRY OPERATIONS</b>	<b>NUMBER OF FULL TIME EMPLOYEES</b>	<b>NUMBER PART TIME EMPLOYEES</b>
\$	\$		

Breed and discipline of horses: \_\_\_\_\_

4. Does applicant own horses?  Yes  No If yes, how many and use: \_\_\_\_\_

Describe applicant's experience with horses \_\_\_\_\_

5. How many horses, not owned by applicant, are stabled OR pastured at applicant's premises? \_\_\_\_\_

6. Does applicant operate the business from:  Owned Premise  Leased Premise  Applicants Vehicle

## CERTIFICATES OF INSURANCE REQUESTED FOR

Owner of Premises: Name \_\_\_\_\_

Address \_\_\_\_\_

Certificate holder Only  Additional Insured

## WHO IS RESPONSIBLE FOR FENCE MAINTENANCE & REPAIR

Owner  Lessee

## RIDING FACILITIES

Arena:  Indoor  Outdoor

DO YOU HAVE OPERABLE FIRE EXTINGUISHERS VISIBLE AND READILY ACCESSIBLE IN YOUR STABLES  Yes  No

IN OTHER OUTBUILDINGS/BARNES  Yes  No

Do you post safety rules?  Yes  No

Are "No Smoking" signs posted?  Yes  No

Is the equine law for applicant's state posted?  Yes  No

7. Do you maintain dogs on the described premise?  Yes  No

Are dogs taken with applicant on service calls?  Yes  No

Number / Breed \_\_\_\_\_

HAS ANY DOG BITTEN OR CAUSED INJURY TO ANYONE  Yes  No  
 IF YES, PROVIDE DETAILS \_\_\_\_\_

Are dogs confined while work is being done?  Yes  No

8. Are horses shod in an area away from public or other horse traffic?  Yes  No

Describe restraint methods used while shoeing:  cross ties  live handler  other:

Describe other safety procedures applicant has in place

### APPRENTICES / HELPERS

1. Does applicant employ additional certified or non-certified dentists, apprentices, helpers?  Yes  No  
List **ALL** Practitioners / Apprentices / Helpers (Must be at least 18 years old)

2. Name

Employee  Independent

Payroll \$

Number of years experience

Dentistry School?  Yes  No

Name

Employee  Independent

Payroll \$

Number of years experience

Dentistry School?  Yes  No

Name

Employee  Independent

Payroll \$

Number of years experience

Dentistry School?  Yes  No

Does applicant carry workers compensation?  Yes  No

Date of Birth : \_\_\_\_\_

Apprentice  Helper

Dentist  None

Any license/certification:  Yes  No

Date of Birth :

Apprentice  Helper

Dentist  None

Any license/certification:  Yes  No

Date of Birth :

Apprentice  Helper

Dentist  None

Any license/certification:  Yes  No

This policy provides no workers compensation coverage

### EQUIPMENT / TOOLS / SUPPLIES

If coverage is needed please complete this section.

Total value of all owned transportable equipment (excluding vehicle & trailer): \$ \_\_\_\_\_

Are all tools and equipment locked in the vehicle and/or trailer when not in use?  Yes  No

(Locked vehicle warranty applies)

Is there a working alarm system on vehicle?  audible and/or  disabling?

Is there a working fire extinguisher with current inspection tag in vehicle?  Yes  No

Is applicant's vehicle and equipment parked in visible sight of applicant's work area?  Yes  No

If no, where is it parked:

Does applicant have a shop on premises?  Yes  No If yes, what is the square footage \_\_\_\_\_

Does applicant sell dental equipment and products?  Yes  No (No products liability provided.)

If yes, what kind of equipment and products? \_\_\_\_\_ What are the annual sales receipts? \$ \_\_\_\_\_

**PREVIOUS 3 YEARS CARRIER INFORMATION REQUIRED (IF NO PREVIOUS CARRIER, STATE NONE)**

COMPANY	POLICY NUMBER	POLICY PERIOD	PREMIUM	NUMBER OF CLAIMS	LOSSES AND RESERVES

HAVE YOU HAD ANY LOSSES IN THE PAST FIVE (5) YEARS – IF YES, GIVE APPROXIMATE DATES AND EXPLANATIONS INCLUDING PAYMENTS MADE  
 Yes     No

HAVE YOU BEEN CANCELLED OR DENIED COVERAGE IN THE LAST THREE (3) YEARS – IF YES, PLEASE EXPLAIN  
 Yes     No

IF NO PRIOR COVERAGE STATE REASON:

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. I/We understand and agree that this application shall form a part of any policy issued.

**FRAUD WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

**WARRANTY**

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. I/We understand and agree that this application shall form part of any policy issued and that the Company requires that I/We obtain additional insured certificates of insurance for independent contractors for coverage to remain in effect. I/We hereby make application to The Equestrian Group and it's Companies for Commercial Equine Liability Insurance. I/We understand any policy issued will not provide Worker's Compensation. The insured assigns as security for the total premium and/or fees payable any and all unearned premiums and dividends which may become payable. I/We agree to pay reasonable attorneys fees, costs and expenses necessarily incurred if suit or collection becomes necessary (not to exceed 50%).

APPLICANT'S SIGNATURE <b>X</b>	DATE / /	AGENT'S SIGNATURE <b>X</b>	DATE / /
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Submit to:  
**Allen Financial Insurance Group**  
 13880 N Northsight Blvd Ste C-109  
 Scottsdale, AZ 85261

602.992.1570 FAX 602.992.8327  
[www.EQGroup.com](http://www.EQGroup.com) Email: [brent.allen@eqgroup.com](mailto:brent.allen@eqgroup.com)