



JERRY PARKS EQUINE INSURANCE, INC.
 PARKS INSURANCE CORPORATION

901 SW 60th Ave.
 P.O. Box 770788
 Ocala, FL 34477-0788
 Telephone 352 237 2164
 Fax 352 873-0888

STATEMENT OF HEALTH AND CONDITION

INSURED _____

POLICY NUMBER _____

DURING THE PAST TWELVE (12) MONTHS **OR** TO THE BEST OF YOUR KNOWLEDGE FOR:

(1) _____ (2) _____ (3) _____

- (1) Has the aforementioned animal(s) suffered from or been treated for:
- | | (1) | | | | (2) | | | | (3) | | | |
|-------------------------------|-----|--------------------------|----|--------------------------|-----|--------------------------|----|--------------------------|-----|--------------------------|----|--------------------------|
| A) COLIC | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| B) COLIC RELATED ILLNESS | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| C) LAMINITIS/FOUNDER | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| D) DEGENERATIVE JOINT DISEASE | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| E) NEUROLOGICAL DISORDER | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| F) OCD LESIONS | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| G) EPM | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
| H) NAVICULAR DISEASE | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | <input type="checkbox"/> |
- (2) Has the aforementioned animal(s) suffered from any other injury, illness, disease or undergone any surgery?
 YES NO
- (3) Has there been any evidence of contagious or infectious disease where the animal(s) is/are boarded?
 YES NO
- (4) Has the above listed animal(s) been castrated, fired, blistered, de-nerved, operated on or received treatment for lameness?
 YES NO
- (5) Has the above listed animal(s) received any medication on a short term or long term basis?
 YES NO
- (6) Does the animal(s) have any vices, objectionable habits or faulty conformation that could affect its ability to be used for the purpose described herein?
 YES NO
- (7) Does the animal(s) have any melanomas, sarcoids, tumors, cysts or any other type of growth?
 YES NO
- (8) If "yes" to any question from (1) to (7), has animal(s) fully recovered?
 YES NO

FURNISH DETAILS INCLUDING **DATE** OF INJURY/ILLNESS:

**NOTE: THE INSURANCE COMPANY
 RESERVES THE RIGHT TO EXCLUDE
 COVERAGE FOR A MEDICAL CONDITION
 WHICH PRE-EXISTS THE INCEPTION
 DATE OF THE POLICY.**

STATEMENT OF CONDITION

I declare to the best of my knowledge and belief that the animal(s) listed on the above schedule are in normal, healthy, sound, condition. I further declare that during the past twelve months, the above listed animal(s) have been free from any **ILLNESS, INJURY, DISEASE, OR ACCIDENT**. I understand and agree that this certificate shall be the basis of the insurance contract, and if anything is falsely stated or information is withheld to influence the company's decision to bind coverage, the insurance contract will be null and void. Any exceptions must be noted _____.

Immediate notice must be given of ALL illness, disease, lameness, injury, death, accident or elective or emergency veterinary treatment involving any animal insured under this policy. Notice may be given by you, your representative or other person having care, custody and control of such animal.

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.

DATE SIGNED _____ PRINT NAME _____ SIGNATURE OF INSURED _____