

**McNamara Company**  
1330 Hwy 96 ~ St. Paul, MN 55110  
Phone 651-426-0607 FAX 651-426-5790

**Health Condition Information Form**

Name of Insured: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Horse: \_\_\_\_\_ Horse's Exact Use: \_\_\_\_\_ Level: \_\_\_\_\_

***This horse has been treated for an injury, illness, or disease during the policy year. For underwriting purposes, please be as specific as possible when providing the below information. A veterinarian narrative or report may also be included with this form.***

***Please address each health issue with as much detail as possible.***

Onset date of condition: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment(s) and dates: \_\_\_\_\_

Current status: \_\_\_\_\_

How condition resolved and when: \_\_\_\_\_

Has the horse returned to full work? If yes, provide date. If no, provide expected schedule and/or prognosis for return to prior activity level:

Is the horse back to showing/competition? If yes, provide current show/competition record: \_\_\_\_\_

Does the horse currently receive any medications / supplements / treatments to prevent reoccurrence? Yes  No

If yes, explain and provide frequency: \_\_\_\_\_

Additional information or comments: \_\_\_\_\_

**DECLARATION**

*I understand and agree that the policy to be issued shall be founded, in part, upon the statements contained herein and prior policy information and this statement shall be the basis of the contract and if anything be falsely stated, or information withheld, to influence the Company's decision, the insurance shall be null and void.*

\_\_\_\_\_  
**Signature of owner (s) of above named animal**

Date: \_\_\_\_\_