KIGER INSURANCE, INC. P O Box 2203 Lexington KY 40588-2203 859 225 5050 FAX: 859 225 5230

VET CERTIFICATE FOR EQUINE MORTALITY INSURANCE

The purpose of this examination is to identify and examine the involved horse in accordance with this Certificate, and to report to the company any medical facts known to you and/or obtained by you in the examination. Horses should be examined in motion.

I, _____ do hereby certify that I am a veterinarian specializing in Equine Practice, holding a current license to practice medicine in the state of _____ and have this day examined:

Thoroughbred

Date of Birth Breed Sex Color

Sire Dam

Owned by:

Name

Pulse and respiration normal?	Yes ☐	No ☐	History or evidence of nerving?	Yes ☐	No ☐
Temperature normal?	Yes ☐	No ☐	If male, are both testicles evident?	Yes ☐	No ☐
Eyes clinically normal?	Yes ☐	No ☐	Has horse been castrated?	Yes ☐	No ☐
Heart ausculated?	Yes ☐	No ☐	Any report or clinical evidence		
History or evidence of bleeder?	Yes ☐	No ☐	of surgery?	Yes ☐	No ☐
Vaccinated against WEST NILE VIRUS	Yes ☐	No ☐	If mare, is she reported in foal?	Yes ☐	No ☐
The external genitalia of this breeding stallion appear normal in size and consistency for his age and breed				Yes ☐	No ☐

If any surgery has been performed, describe type of surgery and give date of surgery_____

_____

If surgery has been performed, has horse clinically recovered? _____

Is there any likelihood of future danger to life or limb as a result of such surgery? _____

Any clinical evidence of lameness, faulty conformation (angular, flexural, laxity), joint swelling or localized limb edema or other abnormal conditions? If yes, give details_____

Any colic within last 12 months: Yes ☐ No ☐ NTMK ☐

In your opinion or to your knowledge, are there any additional medical facts that should be brought to the attention of the Company?

_____

_____

Is there evidence of vices or objectionable habits? Yes ☐ No ☐ Is the stabling adequate? Yes ☐ No ☐

Has official E.I.A. Test been run: _____ Date? _____ Lab No. _____ Result _____

ADDITIONAL REQUIREMENTS FOR FOALS 24 HOURS TO 45 DAYS:

Was birth normal with no complications?	Yes ☐	No ☐	**Date & Time of Birth** _____		
Was foal born premature/dysmature?	Yes ☐	No ☐	Any flexural deformities?	Yes ☐	No ☐
Is umbilicus dry and normal?	Yes ☐	No ☐	Does foal have patent urachus?	Yes ☐	No ☐
Did foal stand and nurse normally?	Yes ☐	No ☐	**White Blood Cell Count & Date Taken:**_____		

IgG Reading(s) and Date(s) taken (list all)_____

Has foal received any medication, plasma or colostrums supplement? _____ If yes, list meds & dates given_____

Is a nurse mare being used for this foal? Yes ☐ No ☐ If so, has nurse mare accepted the foal? Yes ☐ No ☐

Additional Remarks or Information (note rib fractures, hernia, need for therapeutic meds): _____

_____

This certificate has been completed by the examining veterinarian to the best of his or her ability as a licensed veterinarian.

DATE OF EXAMINATION: _____ **TIME OF EXAMINATION:** _____

By: _____ Address: _____

Signature City, State, Zip Code

_____ Phone: _____

Print Name