

## INSURANCE PLAN FOR HORSE SHOWS

- NAMED INSURED:** The Horse Show Organization, while acting in the scope of their duties.
- ADDITIONAL INSURED:** The Sponsoring Organization, Individual Committee Members, Officials, Judges, Course Designer, and Premise Owner with respect to their liability arising from the acts they perform at the direction of and within the scope of their duties for the insured.
- PREMIUM:** Premium charge is based on the number of show days, not including the two days which may be required for preparation, “move-in” and dismantling, “move-out” days. If the public is invited onto the premises, additional public event days must be declared.
- Special premium charges may apply. To obtain premium quotation for shows open five days or longer, detailed information is required, including estimated total gate receipts for the show, number of spectators per day and seating capacity.
- POLICY TERM:** The period required for the preparation and the dismantling of the show, usually one day prior and one day after the show, effective 12:01 a.m.
- IMPORTANT:** The insured must require that all independent contractors (including concessionaires on the show grounds) furnish the insured with a Certificate of Insurance as evidence that Worker’s Compensation Insurance and Public Liability Insurance is in force during the show.
- PRINCIPAL COVERAGES:** Commercial Liability Coverage - Bodily Injury and Property Damage; Medical Payments; Products/Completed Works; Fire Legal Liability; Personal and Advertising Injury Liability.

**Please Note:** Medical payments coverage is provided for all participants providing the insured has secured a signed Release from each entrant.

THIS IS A BRIEF DESCRIPTION. PLEASE REFER TO THE ACTUAL POLICY AND ENDORSEMENTS FOR COVERAGE DETAILS.

*Complete Application on Reverse Side*

# APPLICATION FOR HORSE SHOW INSURANCE

**REFER TO THE DESCRIPTION OF THE INSURANCE PLAN FOR HORSE SHOWS  
ON THE REVERSE SIDE OF THE APPLICATION**

HORSE SHOW ORGANIZATION (INSURED)		NAME OF SHOW	
SHOW MANAGER OR CONTACT PERSON	EMAIL ADDRESS	TELEPHONE NUMBER (     )	
ADDRESS/CITY/STATE/ZIP CODE			
LOCATION OF SHOW GROUNDS			
SHOW DATE(S)		MOVE-IN DATE	MOVE-OUT DATE
CERTIFICATES OF INSURANCE REQUESTED FOR <input type="checkbox"/> Owner of Premises: Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ <input type="checkbox"/> Certificate Holder Only <input type="checkbox"/> Additional Insured  <input type="checkbox"/> Other (Explain insurable interest, if any): _____ Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ <input type="checkbox"/> Certificate Holder Only <input type="checkbox"/> Additional Insured, Subject to Company Approval			
REQUESTED LIMITS OF LIABILITY <input type="checkbox"/> \$ 500,000/ Occurrence <input type="checkbox"/> \$1,000,000/ Occurrence <input type="checkbox"/> Other \$ _____ Occurrence \$1,000,000 Aggregate        \$2,000,000 Aggregate                      \$ _____ Aggregate  <p style="text-align: center;"><b>\$5,000 MEDICAL PAYMENTS COVERAGE IS INCLUDED &amp; \$50,000 FIRE LEGAL LIABILITY IS INCLUDED.</b>  <b>INQUIRE ABOUT THE AVAILABILITY OF HIGHER LIMITS AND TRIPLE AGGREGATE.</b></p>			
ESTIMATED # of ENTRIES	ESTIMATED SPECTATORS PER DAY	ESTIMATED GROSS GATE RECEIPTS (FOR SHOWS RUNNING MORE THAN FOUR DAYS) \$	
SEATING <input type="checkbox"/> Grandstands <input type="checkbox"/> Bleachers	ARENA TYPE <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor	SEATING CAPACITY	
IS YOUR SHOW RECOGNIZED BY AHSA <input type="checkbox"/> Yes <input type="checkbox"/> No    Competition #		IS YOUR SHOW RECOGNIZED BY A NATIONAL ASSOCIATION OTHER THAN AHSA <input type="checkbox"/> Yes <input type="checkbox"/> No    If "YES" which one:	
DO YOU OBTAIN A SIGNED RELEASE FROM ALL ENTRANTS <input type="checkbox"/> Yes <input type="checkbox"/> No    Attach copy of the Release to this application.			
IS THE WARM UP AREA FENCED <input type="checkbox"/> Yes <input type="checkbox"/> No	SECURITY ON SITE <input type="checkbox"/> Yes <input type="checkbox"/> No	AMBULANCE OR EMT <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>NOTE: HAVE YOU HAD ANY CLAIMS IN THE PAST THREE YEARS?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO    INITIAL HERE, PLEASE: IF "YES," PROVIDE DETAILS ON SEPARATE SHEET AND ATTACH TO APPLICATION			
STANDARD FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties.			
APPLICANT'S SIGNATURE <b>X</b>	DATE	AGENT'S SIGNATURE <b>X</b>	DATE
AGENCY NAME <b>BUXTON Equine</b>		AGENCY CODE	EMAIL ADDRESS <b>bill@buxtonequine.com</b>
MAILING ADDRESS <b>PO Box 6823, Lake Worth, FL 33466-6823</b>		TELEPHONE NUMBER <b>(561) 585-0900</b>	FAX NUMBER <b>(561) 586-0870</b>

**ORIGINAL APPLICATION MUST BE RETURNED**