

Waiting Period Health Assessment Form



PART 1 PET OWNER/POLICYHOLDER TO COMPLETE

Instructions:

1. Complete and sign Part 1 of this form.
2. Arrange for a Health Assessment Exam up to 3 days before or within 7 days after your initial policy effective date.
3. Have your veterinarian complete and sign Part 2 of this form during your pet's Health Assessment Exam.
4. Submit this completed 3-page form to us at wpwaiver@petsbest.com within 30 calendar days of the Health Assessment Exam.

In order for us to modify the waiting period, you must meet each of the following requirements:

1. A qualifying exam of your pet by a veterinarian that includes an assessment of all body systems and parts;
2. the results of the exam need to be documented at the time of exam on this Waiting Period Health Assessment Form;
3. the qualifying exam must occur within 3 days prior to or 7 days after your initial policy effective date; and
4. the Waiting Period Health Assessment form must be provided to us at wpwaiver@petsbest.com within 30 calendar days of your qualifying exam.

If the Waiting Period Health Assessment requirements are met, the waiting period will be waived to either the policy period effective date or the day after the qualifying exam, whichever is later. This waiver does not alter the pre-existing conditions exclusion. Please refer to your policy for information about waiting periods.

Your Information

Your Name: _____

Phone: _____

Email: _____

Pet Information

Pet Name: _____

Pet Breed: _____

Pet Age: _____ Dog ☐ Cat ☐

1. Is your pet currently sick or injured, or did they recently experience an accident, display clinical signs or symptoms, or receive treatment from a veterinarian for any reason? Yes ☐ No ☐
If yes, describe: _____
2. Is your pet currently on any medication, supplements or prescription food? Yes ☐ No ☐
If yes, describe: _____
3. Has your pet ever been sick, injured or treated by a veterinarian in the past? Yes ☐ No ☐
If yes, describe: _____
4. Has your pet been seen by any veterinarian other than the one conducting this exam? Yes ☐ No ☐
If yes, who and when: _____

You certify that you did not make a misrepresentation to us which includes a statement that is false, partially false, or which does not fairly reflect the truth. You understand that if you did, we may deny your request to modify the waiting period. You authorize any veterinarian who has ever seen or treated your pet to provide all medical records as may require. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

X

Pet Owner/Policyholder Signature

Date

Pet insurance coverage offered and administered by Pets Best Insurance Services, LLC is underwritten by American Pet Insurance Company (NAIC #12190), a New York insurance company headquartered at 6100 4th Ave. S. Suite 200 Seattle, WA 98108, or Independence American Insurance Company (NAIC #26581), a Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254. Pets Best Insurance Services, LLC (NPN #8889658, CA agency #0F37530) is a licensed insurance agency located at 10840 Ballantyne Commons Parkway, Charlotte, NC 28277. Each insurer has sole financial responsibility for its own products. Please refer to your declarations page to determine the underwriter for your policy. Terms and conditions apply. See your policy for details.

Waiting Period Health Assessment Form

PART 2 VETERINARIAN TO COMPLETE DURING EXAM

This form must be completed on the same day as the health assessment exam, by the Veterinarian who performed the exam.

Pet Name: _____		Veterinarian's Name: _____	
Pet Breed: _____		Clinic/Hospital Name: _____	
Pet Species: _____		Clinic/Hospital Address: _____	
Pet Age: _____		Clinic/Hospital Phone: _____	
Body Condition Score (1-9): _____	Date of Exam: _____	Clinic/Hospital Email: _____	

Does this pet have a diagnosis, clinical signs or symptoms associated with any of the following conditions? Please answer the following based on your comprehensive, in-person physical examination and assessment:			
	CONFIRMED This pet has a confirmed diagnosis either past or present	POSSIBLE This pet has possible signs or symptoms, but no confirmed diagnosis	No
Addison's Disease (Hypoadrenocorticism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Degenerative Joint Disease (DJD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brachycephalic Airway Syndrome (BOAS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Renal Failure/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Valvular Disease or Structural Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cushing's Disease (Hyperadrenocorticism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative Myelopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Disease: Periodontal, Stomatitis, Tooth Resorption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus (DM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism/ Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Bowel Disease (IBD) /Chronic Enteropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune Mediated Thrombocytopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intervertebral Disc Disease (IVDD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ligament and Knee Conditions (CCL/MPL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Megaesophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wobbler's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: Does this pet have any clinical signs, symptoms or diagnosis of ANY other condition(s) not listed above? If Yes - please describe the condition(s), clinical signs or symptoms and when they began:			

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Please select either normal or abnormal, and if abnormal describe.		
	Normal	Abnormal/ Problem
Eyes (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>
Ears (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>
Skin (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (if this pet has allergies, to what/which kind?):	<input type="checkbox"/>	<input type="checkbox"/>
Lumps, bumps, growths, lymph nodes (if abnormal, describe type and location):	<input type="checkbox"/>	<input type="checkbox"/>
Teeth and gums (if dental disease is present, what grade?):	<input type="checkbox"/>	<input type="checkbox"/>
Brachycephalic conformation — If pet is Brachycephalic, select abnormal (if abnormal, does the pet have any breathing or digestive problems or has surgery been recommended or performed?):	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular (if abnormal, describe; if a murmur is present, what grade):	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>
Cruciate ligaments, stifle(s) (if there is laxity, pain or limping, which limb(s)?):	<input type="checkbox"/>	<input type="checkbox"/>
Luxating patella (if there is luxation, which limb(s) and what grade?):	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic – joints, extremities (if abnormal, describe and indicate which area(s)/joint(s)):	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic – back, neck, spine (if abnormal, describe and indicate location):	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedic - hips (if abnormal, describe):	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I've taken reasonable care not to make a misrepresentation and the answers and statements made in this form and any supporting documentation has been answered honestly, accurately and to the best of my knowledge based on a physical examination personally performed by me. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

_____ Veterinarian Printed Name	^x _____ Veterinarian Signature	_____ Veterinary License Number	_____ Date
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