NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN
INSOLVENCY UNDER THE MINNESOTA INSURANCE
GUARANTY ASSOCIATION LAW

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
7600 Parklawn Ave # 460
Edina, MN 55435-5137
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to $300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

MedPro Group
a Berkshire Hathaway company

Issuing Company:
The Medical Protective Company
Fort Wayne, Indiana

STUDENT DENTAL BOARD/EXTERNSHIP APPLICATION

Please complete all information requested. **Note: application must be received at least two weeks prior to exam/externship date.**

Please print

A. Last Name _____ First Name _____ M.I. _____ Suffix _____

Date of Birth (MM/DD/YYYY) _____ Social Security Number (Optional) _____

Mailing Address _____

City _____ State _____ Zip _____

Phone _____ E-Mail _____

Name of school _____ Graduation Date (MM/DD/YYYY) _____

B. Forwarding Address After Graduation:

Street _____

City _____ State _____ Zip _____

C. Planned Location of Practice After Graduation:

Street _____

City _____ State _____ Zip _____

D. Have you ever been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No

E. Have you ever been charged with or convicted of a felony? ☐ Yes ☐ No

If Yes, give details: _____

F. Have you ever had any chronic illness or physical defect? ☐ Yes ☐ No

G. Have any claims or suits ever been filed against you as a result of professional services rendered? ☐ Yes ☐ No

If Yes, give details, amounts paid, dates: _____

H. Has any professional liability insurance company ever declined, refused, cancelled, or non-renewed your coverage, or have you ever had an involuntary deductible or surcharge assessed against your policy? ☐ Yes ☐ No

If yes, please explain and indicate the date(s): Please explain _____ (MM/YYYY) _____

I. I will take the following examination(s)/externship(s): _____

City of Examination/Externship: _____ State of Examination/Externship: _____

Examination/Externship Dates (MM/DD/YYYY): From: _____ To: _____

J. Are you taking a specialty board/externship exam? ☐ Yes ☐ No

If Yes, please identify specialty: _____

K. Dental Board/Externship Professional Liability: $1,000,000/$3,000,000 limits

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I also acknowledge that if approved, coverage is only for services rendered during a dental internship prior to graduation and/or dental board/externship examination pursuant to professional licensing.

Signature _____ Date _____

Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com

FOR COMPANY USE ONLY

Dates of Coverage: From: _____ To: _____

Date: _____ Acct: _____ Initials: _____