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.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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: _____