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.

I understand that if I cancel or terminate any coverage that may be provided by the Company, earned premium shall be computed in accordance with the standard short rate tables and procedures with a maximum penalty of up to 11%. Premium adjustments shall be made within a reasonable period of time after cancellation or termination. However, payment or tender of unearned premium shall not be a condition of cancellation.

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: _____