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.

Compliance with Illinois Bulletin 2011-06 and The Religious Freedom Protection and Civil Union Act

The Medical Protective Company recognizes the rights afforded to individuals under The Religious Freedom Protection and Civil Union Act which states:

"The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

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: _____