Application - Student Dental Board Coverage

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

The Medical Protective Company

Fort Wayne, Indiana

Please print

I. Name | Social Security No. | Date of Birth

Mailing Address

City | State | Zip

Home Phone | Work Phone

II. Forwarding address after graduation

Street City St Zip

Name of school | Graduation Date (MO/DAY/YR)

Email Address

III. Planned location of practice

Street City St Zip

IV.

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

B. Have you ever been charged or convicted of a felony? ☐ Yes ☐ No
If Yes, give details: _____

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

D. Have any claims or suit ever been filed against you as a result of professional service rendered? ☐ Yes ☐ No
If Yes, give details, amounts paid, dates: _____

E. Has this form of insurance or other similar insurance ever been cancelled, refused or nonrenewed? ☐ Yes ☐ No
If Yes, give reason: _____

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

City of Examination: _____

State of Examination: _____

Examination Dates: From: _____ To: _____

VI.

Are you taking a specialty board exam? Yes ☐ No ☐

If Yes, please identify specialty _____

VII.

Dental Board 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 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: _____