INDIANA
DENTAL
NEW GRADUATE
APPLICATION

*If previously insured with Medical Protective, please provide the policy number.

Policy # ____________________

Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com
If you have questions, please contact your agent or call 1-800-4-MedPro
## I. GENERAL INFORMATION

*Please print legibly. Please answer all questions. If a question is not applicable, state “N/A”.*

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<th>A. Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Suffix</th>
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Date of Birth (MM/DD/YYYY) ____________________________ Social Security Number (Optional) ____________________________

National Provider Identifier (NPI) ____________________________

E-Mail ____________________________

Business Fax ____________________________ Business Phone ____________________________ Residence/Cell Phone ____________________________

**B. Practice Location(s):**

(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. **Primary Location:**

   % of Practice __________ Type of Location: [ ] Hospital [ ] Office [ ] Residence

   Location Name ____________________________

   Number and Street ____________________________ Suite ____________________________

   City ____________________________ County ____________________________ State ____________________________ Zip Code ____________________________

2. **Additional Location:**

   % of Practice __________ Type of Location: [ ] Hospital [ ] Office [ ] Residence

   Location Name ____________________________

   Number and Street ____________________________ Suite ____________________________

   City ____________________________ County ____________________________ State ____________________________ Zip Code ____________________________

**C. Preferred Billing and Correspondence Address:**

[ ] Location Number (From Section B. above) __________ [ ] Other (please enter below)

Number and Street ____________________________ Suite ____________________________

City ____________________________ State ____________________________ Zip Code ____________________________

## II. EDUCATIONAL BACKGROUND

A. **Have you completed a risk management education course within the last twelve (12) months?**

[ ] Yes [ ] No

If you have answered yes, did the course provide all of the following: [ ] Yes [ ] No

1. A minimum of three continuing dental education (CDE) hours;
2. Sponsored by an approved national/regional dental education sponsor; and
3. Strictly adhere to a risk management (loss prevention) curriculum

B. **Dental School:**

1. Name of School ____________________________

   City ____________________________ State ____________________________ Country ____________________________

   Degree ____________________________ Completed From (MM/YYYY) __________ to (MM/YYYY) __________
C. Residency:
(Please list all resident training locations - i.e. Residency Specialty Training, Anesthesia Residency Training, etc.)
(If you were involved in more than one specialty training program, please enter each program separately.)

1. Name of Hospital/Facility/Program
   City__________________________State___________Country___________
   Specialty Type________________
   Completed?  □ Yes  □ No  □ Still in Training
   From (MM/YYYY) ____________  To (MM/YYYY) ____________

2. Name of Hospital/Facility/Program
   City__________________________State___________Country___________
   Specialty Type________________
   Completed?  □ Yes  □ No  □ Still in Training
   From (MM/YYYY) ____________  To (MM/YYYY) ____________

III. RATING INFORMATION

A. Please check your present specialty:
   □ General Dentist  □ Prosthodontist
   □ Orthodontist  □ Oral Pathologist
   □ Pediatric Dentist  □ Dental Anesthesiologist
   □ Endodontist  □ Pain Management (Please explain)
   □ Periodontist  □ Other (Please explain)
   □ Oral & Maxillofacial Surgeon
   □ Oral & Maxillofacial Surgeon
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B. Please check procedures you will perform in your practice:
   Third Molar Extractions (CPT/CDT Codes)
   □ Erupted (D7110, D7120, D7210)
     Year you began this procedure (YYYY) ____________
   □ Partially Impacted (D7220, D7230)
     Year you began this procedure (YYYY) ____________
   □ Fully Impacted (D7240, D7241, D7250)
     Year you began this procedure (YYYY) ____________
   □ Surgical Placement of Implant Fixtures
     Year you began this procedure (YYYY) ____________
   □ Botox, Dermal Fillers (i.e. Injections)
     Year you began this procedure (YYYY) ____________
   □ Other
     Please explain

C. States in which you hold a license to practice dentistry:
Please check the appropriate box to indicate the status of your license. Exclude state abbreviation from license number.

1. State___________License #___________Active  □  Inactive  □  Temporary  □  Pending  □
2. State___________License #___________Active  □  Inactive  □  Temporary  □  Pending  □
3. DEA License?  □ Yes  □ No

D. To which dental societies or associations do you belong?

E. Please indicate estimated average weekly hours of practice per week for which you require coverage:

IV. ADDITIONAL PROFESSIONAL INFORMATION

A. Do you treat or review treatment of federal prison inmates?
   □ Yes  □ No
   If yes, please explain

B. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, dental license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?
   □ Yes  □ No
   If yes, please explain and indicate the date(s):  Please explain ____________ (MM/YYYY)

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IV. ADDITIONAL PROFESSIONAL INFORMATION (CONTINUED)

C. Have you ever been accused of sexual misconduct of any kind?  
☐ Yes ☐ No
If yes, please explain and indicate the date(s):   Please explain (MM/YYYY)

D. Have you ever incurred or become aware of having a condition that impairs your ability to practice your dental specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction to alcohol, narcotics, or other controlled substances, etc.)  
☐ Yes ☐ No
If yes, state condition, date(s) and identify your treating physician in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type(s) of Illness
Date(s) of Treatment(s):    From (MM/YYYY)      To (MM/YYYY)
Treating Physician(s):     Name(s)                      Address(es)

E. Are you affiliated with a group that has more than three active locations?  
☐ Yes ☐ No

F. Are you affiliated with a management service organization or dental practice franchise?  
☐ Yes ☐ No

V. PRACTICE ORGANIZATION INFORMATION

A. Name of all your partnership’s professional corporations or associations (including DBA’s and Individual Dentists).

B. Have all legal entities, assumed names, DBAs, etc. been filed with the Indiana Secretary of State’s office?  
☐ Yes ☐ No
If no, please explain

C. Is this entity or employer currently insured with The Medical Protective Company?  
☐ Yes ☐ No
If yes, please provide The Medical Protective Company individual, corporation or partnership policy number and group number, if known.

Policy #    Group #

D. Do you desire coverage for this entity?  
☐ Yes ☐ No
If yes, please contact your agent or Med Pro customer service (800-4Medpro) to complete an entity application for consideration.

VI. LOSS INFORMATION

Please complete the Loss Information Supplement for each incident, claim or suit.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints etc...)

For question B below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Are you now, or have you ever been, involved in a claim or suit arising out of the rendering or failure to render professional services?  
☐ Yes ☐ No
If yes, how many?

B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you?  
This includes but is not limited to the following:
-Cancer -Death -Permanent Neurological Injury -Permanent Nerve Injury
If yes, how many?
VIII. ASSIGNMENT OF RIGHT TO CANCEL COVERAGE

Would you like to assign an employer or a named third party the right to cancel your coverage and receive any premium refunds?  

Yes    No

If yes, please complete the following statement:

By initialing, I assign to the following employer or named third party (include name and address), both the right to cancel my policy and to receive any unearned premium. However, I do request that copies of all correspondence, formal notices, etc., be sent to me at the last address of record. This assignment may be revoked by me at any future time by sending written notice to The Medical Protective Company’s home office, P.O. Box 15021, Fort Wayne, Indiana 46885-5021.

Name

Number and Street

City, State, Zip

Phone Number

Please Note: Your right to cancel and receive a premium refund will automatically be assigned to a third party finance company if it pays your premium on your behalf.

Initial Here
IX. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

Please initial the statements below:

Mandatory: All applicants must read and initial the following:

Any person who knowingly files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

X. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any Attachments, shall be the basis of the contract with the Company. I agree to notify the Company if there is any future material change in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as “received” by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Signature ________________________________ Date Signed ________________________________

Type or Print Name ________________________________

XI. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.