Dental Professional Liability Insurance
Board and Interview Coverage Dentist Application

DentistCare℠
ProAssurance
Treated Fairly

ProAssurance American Mutual, A Risk Retention Group
PO Box 590009 • Birmingham, AL 35259-0009 • 800.625.7814 • Fax 205.868.4040

1. Personal Information

Name: _____ Degree Pursued: _____

Date of Birth: _____ Social Security Number: _____ Gender: Male ☐ Female ☐

Home Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Permanent Email Address: _____ Alternate Phone: _____

2. Dental School Information

School Name: _____

School Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Preferred Mailing Address: ☐ Home ☐ School Graduation Date: _____ Board Exam Date: _____

Coverage is subject to limits of liability of $1,000,000 each professional incident and $3,000,000 policy aggregate, if this application is accepted.

No coverage for the practice of dentistry. Coverage applied for is limited to your participation in required clinical examination for licensure as a dentist. Coverage is also extended to your limited participation in interviewing for a position after successful completion of your licensure examination provided you do not receive payment for services as a dentist, except for reimbursement of incidental expenses. Coverage is not provided for the practice of dentistry as an employee, independent contractor or owner of a dental practice.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature: _____ Date: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

Agent's Name	Agency Name
Signature	Agency Address
Date	Phone