



### Fortress Insurance Company - Student Plan Application

Please complete all information requested. **Application and payment must be received in our office at least two weeks prior to exam date.**

Name		Social Security No.		Date of Birth / /	
Street Address					
City			State		Zip
Home Phone		Alternate Phone		Email Address	

Address after Graduation (If known):

Street Address					
City			State		Zip
Name of School				Graduation Date / /	
Planned location of practice:					
Has this form of insurance or other similar insurance ever been cancelled, refused or non-renewed? <b>This question does not apply to MO applicants.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please give a reason:					

Have you ever been treated for alcoholism, narcotic addition or mental illness?                       Yes    No

Have you ever been charged or convicted of a felony?                       Yes    No  
If yes, please give details:

\_\_\_\_\_

\_\_\_\_\_

Have any claims or suit ever been filed against you as a result of professional service rendered?                       Yes    No

If yes, please give details, amount paid and dates:

\_\_\_\_\_

I will take the following examination(s):

\_\_\_\_\_

City of Examination: \_\_\_\_\_ State of Examination: \_\_\_\_\_

Examination Dates                      From: \_\_\_\_\_                      To: \_\_\_\_\_

Agent: \_\_\_\_\_                      Agent License Number: \_\_\_\_\_

Are you taking a specialty board exam?

Yes  No

If yes, please identify specialty: \_\_\_\_\_

Dental Board Professional Liability: \$1,000,000/\$3,000,000 limits      Premium: \$25.00

**IF YOU ARE IN A FUND STATE:**

If you are taking a dental board in a state that has a Patient Compensation Fund, you may elect to check the box to participate in the Fund. If you do elect to participate, you will be billed an additional premium for the Fund coverage.

I choose to participate in the State Fund     I choose not to participate in the State Fund

**WARNING:** Any person who, knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or a statement of claim containing any materially false, incomplete or misleading information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud. Such person may be subject to denial of insurance benefits, civil penalties and/or criminal penalties.

In CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

In NY: Any person who knowingly and with intent to defraud any insurance company or other person 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In VA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I hereby declare that the above statements and particulars are true, 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 the dental school board examination, externship or training program prior to graduation in which the doctor does not collect a fee in excess of the cost of materials.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Dates of Coverage From: \_\_\_\_\_ To: \_\_\_\_\_

Premium Collected \$ \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Authorized Representative)

Acct: \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_