
**REPORT CLAIMS** to:
phyclaims@bbprogram.com or
888-239-2663 (facsimile)

**HEALTH CARE PROFESSIONAL LABILITY COVERAGE PART**
**PHYSICIANS SURGEONS CLAIMS REPORTING FORM**

Broker/Agent:_____ Date of Notice:_____
Contact Name:_____
Phone No.: _____
Email address:_____

**TYPE of INCIDENT/INJURY**:

Incident Notice Only ☐ Notice of Intent ☐ Lawsuit ☐ Board Action ☐

**POLICY INFORMATION:**

Policy No:_____ Date of Incident:_____
Effective Dates: _____ To _____
Retroactive Date: _____
Limits:_____

**INSURED INFORMATION:**

Insured:_____Phone No:_____ Cell No: _____

Email address:_____

Mailing address:_____DOB:_____
State(s) of Practice:_____


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**CLAIMAINT INFORMATION:**

**(Provide as much information as possible)**

Claimant's Full Name: _____
Address: _____
Gender: _____
DOB: _____
Social security number: _____- ____- _____ (minimum of last 5 digits needed)

**CLAIM INFORMATION:**

Date of Insured's First Notice: _____
Date of Incident: _____

Place of Incident: _____ City/State _____

Date Patient FIRST SEEN: _____

Date Patient LAST SEEN: _____

Brief Description of Loss:_____
_____
_____
_____
_____
_____
_____