MAILING ADDRESS/ PRACTICE LOCATION CHANGE FORM

Named Insured(s) ____

Type of Policy: ☐ Professional Liability Policy Number ______________________________

☐ Workers' Compensation Policy Number ______________________________

☐ Property (mailing address changes only) Policy Number ______________________________

Contact Name_________________________________ Phone (______)____________________

Alternate Phone ______________________________

☐ Please change my practice location to:

New Address____
City____
County____State__________Zip_____
Phone______________________________ *Fax* ___________________________________

☐ Please change my mailing address to: ☐ Same as practice location

New Address____
City____
County____State__________Zip_____
Phone______________________________ *Fax* ___________________________________

Signature of Named Insured

____Date____/_____/____

Please Note:
Additional information and underwriting may be required by the insurance company. Insurance coverage cannot be bound, changed, or cancelled via this change form without written confirmation from a B&B Protector Plans, Inc. representative. If you do not receive written confirmation please contact our office at 800-467-8734 ext 1.

THIS IS A FAX FORM. NO COVER LETTER NEEDED.
Fax: (813) 222-4288 Ph: (800) 467- 8734 Attention: PSP