

# OCG & Associates, Inc.

Oscar M. Cartagena  
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www.ocginsurance.com

## Group Health/ Dental Insurance Quote Request

### EMPLOYER INFORMATION

Group Name: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Effective date requested: \_\_\_\_\_

Prior Coverage:  Yes  No

*If Yes, please indicate carrier name & policy effective date:*

\_\_\_\_\_

### EMPLOYEE INFORMATION

Status: E= Employee, ES= Employee & Spouse,  
EC= Employee & Child (ren), F= Family

#	NAME OF EMPLOYEE	SEX M/F	DOB	STATUS
1				
2				
3				
4				
5				

\* Attach completed census if needed.

\* Please fax completed form to (305) 447-9578.

COMPLETION OF THIS FORM DOES NOT OBLIGATE OCG & ASSOCIATES, INC TO OFFER A PREMIUM INDICATION OR BIND COVERAGE. ULTIMATE PREMIUM, COVERAGE TERMS AND CONDITIONS MAY ONLY BE DETERMINED AFTER REVIEW OF A FULLY COMPLETED APPLICATION.