

OCG & Associates, Inc.
Oscar M. Cartagena
7480 Bird Road, STE 610 – Miami – FL 33155
Ph: 305-447-9577 / Fax: 305-447-9578
www.ocginsurance.com

Workers Compensation Quote Request

General Information

Company Name: _____
 Contact Name: _____
 Telephone: _____ Fax: _____ Email: _____

Company Information

Type of Company: C- Corporation, S- Corporation, Limited Liability Company, Partnership, Sole Proprietorship
 Year Established: _____ Number of Employees: _____
 Owner Name: _____ Ownership Percentage: _____
 Owner Name: _____ Ownership Percentage: _____
 Owner Name: _____ Ownership Percentage: _____

Location Information

1. Address: _____ City: _____ State: _____ Zip Code: _____
2. Address: _____ City: _____ State: _____ Zip Code: _____
3. Address: _____ City: _____ State: _____ Zip Code: _____

Occupation Information

Job Description	Number of Employees	Annual Payroll	Location

Insurance History

Prior Insurance Company Name: _____
 Policy Expiration Date: _____
 Annual Premium: _____
 Exemptions : _____
 Three Years of Loss, Runs, and Reports: _____

Please fax completed form to (305) 447-9578. If current or prior insurance declarations page is available, please attach to fax for a better quote.

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.