



Metro Insurance Services
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Group Medical Insurance Application
(Metro GM Quote18)

Group Name: _____ Group Contact: _____

Address: _____ Telephone #: (_____) _____

City: _____ Zip: _____ Fax Number: (_____) _____

Number of full time employees: _____

Current insurance company: _____

Current monthly premium: _____

Renewal Date: _____

Table with 4 columns: Employee Name, Age, Total #, Zip Code. Each row contains checkboxes for EE, ES, EC, and FA.

EE = Employee ES = Employee + Spouse EC = Employee + Children FA = Family
Total # = Total number of family members enrolled including employee.
Zip Code = The zip code of employee's residence is critically important, please include.

If you filled out this form electronically you may EMAIL it to us at: tom@metroinsurance.com
If you printed out this form you may FAX it to us at: (714) 573-7202