

**FORMFIRE QUOTE REQUEST**

Date:

<b>Group Name &amp; Number:</b>	<b>HR Benefit Contact**: Name and Email</b>
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**Please include below ALL DOCTORS and Employees in your office requesting to complete their Medical Information through FormFire to obtain an ODA Wellness Trust quote.**

Title: Dr, Mr, Ms	First Name	Last Name	Date of Hire	Total Hours Per Week	Last 4 Digits SS#	Date of Birth	Email Address

*\*Ineligible employees include: part time employees that work less than 25 hours per week, temporary employees, or employees that have not completed the group probationary period.*

*\*\*HR Benefit Contact to coordinate online process of employees completing health quote questionnaires.*

**RETURN TO:**   
ODA MEMBER BENEFIT  
**Fax: (614) 340-9444**  
**Email: [insurance@oda.org](mailto:insurance@oda.org)**