



Business Friends Program™

Individual & Group Dental, Vision & Prescription Plans

Employee Application

Employer's Name: _____

Employee's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home or Cell Phone Number: _____ E-Mail Address: _____

Social Security Number: _____ Date of Birth: _____

Dependent Information:

	<u>First Name</u>	<u>Last Name</u>	<u>Sex</u>	<u>Date of Birth</u>	<u>Soc. Sec. #</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____

All New Members must Read and Sign Below: I understand that the Benefits are not insurance, it is a professional discount and savings program. I understand that in order to receive the program savings I must access the contracted networks and pay the provider at time of service. I agree to abide by these terms and conditions. I also understand that Medical Benefits Network and their sales associates are not responsible for the out come of the care received or the cost of this care.

PLEASE BE CERTAIN TO CALL OUR OFFICE TO ACTIVATE YOUR MBN CARD BEFORE USING IT. OUR PHONE NUMBER IS: 412-341-1400 OR 1-888-831-7886.

Employee Signature: _____ Date: _____

Employee Print Name: _____

Agent Signature: _____ Date: _____