



Business Friends Program™

Individual & Group Dental, Vision & Prescription Plans

EMPLOYER APPLICATION

Employer's Name: _____

Employer's Address: _____

Employer Email Address: _____

Employer Phone Number: _____ Employer Fax Number: _____

Employer Contact: _____

Total Number of Employees (both full and part-time): _____

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.

Employer Signature: _____ Date: _____

Employer Print Name: _____

Agent Signature: _____ Date: _____