The W⏲rkplace Reward$™
TheWorkplaceRewards.com

Workplace Rewards Program
Employee Application

Employer's Name: ____

Employee's Name:____

Street Address:____

City:______________________ State:______________________ Zip Code:________________

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

Date of Birth:______________________

Dependent Information:

First Name	Last Name	Sex	Date of Birth

1.____

2.____

3.____

4.____

<u>All New Members must Read and Sign Below:</u> 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 outcome 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:__________________