EMPLOYER APPLICATION

COMPANY INFORMATION

Company Name:		
Company Email:	EIN:	Phone:
Current address:		
City:	State & Zip:	Benefits/HR Contact Name:
Owner:		Contact Email:

HEALTH INSURANCE INFORMATION

Current Health Carrier:	Renewal Date:
% paid for Employee:	Payroll Company:
% paid for Employee & Child:	Broker:
% paid to Employee & Spouse:	Plan name:
% paid to Employee & Family:	Section 125: YES NO

DENTAL INSURANCE INFORMATION

Dental Carrier:		
Plan design:		
Renewal Date:		
Plan contribution: Voluntary Employer paid	% paid by Employer:	

VISION INSURANCE INFORMATION

Vision Carrier:	Plan name/type:
Renewal Date:	

EMPLOYEE INFORMATION

Policy of benefits termination:		
Defined Contribution:		
Dependent Programs: Yes No		
Waiting period:	# of Full time:	# of part time:

PLEASE PROVIDE

Copy of most current insurance bill	Company UC2 A form	If you have a current census
Must have signed employee applications	*Voided Check*	Copy of company handbook
Current health plan summary	Current dental plan summary	Current vision plan summary

BANK INFORMATION

Bank Name:	Branch:	Program Cost: (monthly)
Routing # (ABA)	Acct #	

BANK DRAFT CONSENT & SIGNATURES

By signing below, I authorize Medical Benefits Network MBN to provide COBRA services to my company as stated in the COBRA services agreement. I hereby authorize MBN to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit in error to our account listed above. I also do not hold MBN responsible for any payments that ex-employees don't pay for their COBRA payments. In addition, I authorize MBN to draft my bank account monthly for the program cost listed above. I further understand that the Benefits for The Workplace Rewards Program are not insurance, it is a professional discount and savings program. I understand that in order to receive the program savings, I & my employees must access the contracted networks and pay the provider at the 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.

Signature of applicant:	Date:
Print name:	Position: