TRIPLE-S SALUD

BlueCross BlueShield of Puerto Rico

An Independent Licensee of the BlueCross BlueShield Associaton

PO Box 363628 SJ PR 00936-3628 • Tel. 787-774-6060

Policy Application

☐ Group ☐ AXIS ☐ Cobra Law ☐ Association and Colleges

This application should be received on or before 10 days prior to the effective date

FILL OUT THE FORM ON BOTH SIDES / INCOMPLETE APPLICATIONS WILL BE RETURNED WITHOUT PROCESSING

PLEASE PRINT / Please read the instructions on the back of this form before filling out the information

Social Security or Medicare Number | Effective: Month, Day, Year | Type | Sponsor | Org Policy

Name of Group / Section

This contract is ☐ **NEW** ☐ **CONVERSION** ☐ **RENEWAL** ☐ **INDIVIDUAL** ☐ **FAMILY** ☐ **COUPLE**

Main Policyholder

Surnames, Name, Middle Initial | Marital Status | Gender F M | Date of Birth Month Day Year

Mailing Address | Employee Number according to paycheck

Drivers License or Member Number (only applies to associations and colleges)

City | Country / State | Zip Code | E-Mail Address

Position | Date of Employment Month Day Year | Office Phone ( ) | Home Phone ( ) | Mobile Phone ( ) | Fax ( )

Optional benefits requested for you and your direct dependents

BASIC

Name of Personal Physician and Specialty (only for Axis plan) | Name and Medical Group Number (only for Axis plan)

Direct Dependents

Surnames, Name , Initial (Spouse and Children) | Relationship | Date of Birth Month Day Year | Gender F M | Social Security or Medicare Number

Name of Personal Physician and Specialty (only for Axis plan)

Surnames, Name , Initial (Spouse and Children) | Relationship | Date of Birth Month Day Year | Gender F M | Social Security or Medicare Number

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Surnames, Name , Initial (Spouse and Children) | Relationship | Date of Birth Month Day Year | Gender F M | Social Security or Medicare Number

Name of Personal Physician and Specialty (only for Axis plan)

Optional Dependents

Surnames, Name , Initial | Relationship | Date of Birth Month Day Year | Marital Status | Gender F M | Social Security or Medicare Number

☐ **BASIC** | Code: Parent, Depend

Name of Personal Physician and Specialty (only for Axis plan)

Surnames, Name , Initial | Relationship | Date of Birth Month Day Year | Marital Status | Gender F M | Social Security or Medicare Number

☐ **BASIC** | Code: Parent, Depend

Name of Personal Physician and Specialty (only for Axis plan)

Coordination - Indicate if you or your spouse has another health plan:

Name of main policyholder of the other plan | Company | Policy Number | COB Number | COB Code

☐ **BASIC** | Effective Date Month Day Year | Code Parent Depend

Conversion

Prior Triple-S Contract number if this contract is a conversion | Last Payment Month Year | Conversion Month Year | Use SSS | Unpaid SUPS. | Leave COM.

COBRA LAW

COBRA

Reason for requesting "COBRA"

☐ Resignation ☐ Lay-Off ☐ Retirement ☐ Employee enrolled in Medicare ☐ Death ☐ Divorce ☐ Not eligible as dependent ☐ Other

Date of Notice to Employer Month Day Year | "COBRA" effective date Month Day Year | Date of Event Month Day Year | Requested by: ☐ Employee ☐ Direct Dependent

Model PG Rev. 05/2013

THE FOLLOWING PRODUCTS ARE OFFERED AND ADMINISTERED BY TRIPLE-S VIDA, INC. These products are **NOT** licensed by the BlueCross BlueShield. Mark with an X if you are interested in enrolling to one of them:

TRIPLE-S *VIDA*

☐ I request to Triple-S Vida the Life Insurance Benefit of $10,000 for the Main Policyholder.

☐ I request Triple-S Vida the First Cancer Diagnostic policy, sole payment of $5,000 for the Main Policyholder. It has a waiting period of 90 days from the effective date of the policy.

I hereby certify that the main policyholder has not being diagnosed or treated for cancer, nor have been recommended to undergo medical examinations, laboratory tests, biopsies of any other kind of test to discover a possible malign tumor or leukemia or any other manifestation that may suggest cancer. Initials: _____

To be eligible to any of the Triple-S Vida products the main policyholder must be under 65 years of age.

Consent for the exchange of information through electronic media

☐ I agree that Triple-S Salud sends me notices, invoices, reports answers to information requests, complaints or informational material about the plan to the e-mail address provided in this form through secure electronic means. I understand that Triple-S will send the document in a manner that I will be able to print it and keep it for future reference. I understand that with this authorization:

1. I do not lose the right to obtain information in paper if I request it;
2. I am responsible of keeping my contact information updated;
3. When it may be necessary, Triple-S Salud will notify me any change in the equipment or applications specifications necessary to access or save the documents or electronic information they send me

I can revoke this consent at any time by written notice to Triple-S Salud Customer Service Department, in which I will specify my full name, contract number and effective date of the revocation. Initials: _____

Authorization for marketing purposes of products and services of other companies

☐ I authorize Triple-S Salud to share my name, addresses and telephone number with Triple-S Propiedad and Triple-S Vida. This authorization has a validity of 12 months from the date of this application request.

Authorization for activities related to your health plan

When you sign this application and subscribe to Triple-S Salud health plan, you authorize us to use and disclose your clinical and demographic information for the following activities that are inherent to our operations including but not limited to: enrollment, coordination of services, evaluation programs, quality improvement, conditions and case management programs, clinical files utilization audits, fraud investigations, reinsurance, resolution of complaints and grievances, administration, payments and adjustments of claims, share information with business partners that manage services and coverages on behalf of Triple-S Salud and with service providers that provide services and information to credit agencies and business planning. The authorization will be valid while you are enrolled to the health plan. Even after the termination of this contract, Triple-S Salud may use your information to terminate activities regarding your contract or as required or permitted by law.

If you opt to subscribe to any of the Triple-S Vida products, when you sign this application you authorize Triple-S Salud to share with Triple-S Vida the information contained in this application form and your monthly information on enrollment and premium payment. Triple-S Salud does not condition subscription or eligibility for health plan benefits to your choosing the products offered by Triple-S Vida. You may revoke this authorization by writing to the Compliance and Privacy Office, PO Box 363628, San Juan, PR 00936-3628. The revocation will have prospective effect and the Triple-S Vida policy chosen maybe terminated. Triple-S will not receive any compensation as a result from your authorization.

SIGNATURE OF GROUP ADMINISTRATOR	SIGNATURE OF APPLICANT	DATE (MONTH / DAY / YEAR)

INSTRUCTIONS

All shaded sections are the sole use of Triple-S Salud. Please be sure to read the Certificate of Benefits carefully.

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1. Type or handprint in ink the information in the application. Fill out all the blocks in the application, except those that are shaded.
2. All names must be written as follows: last name, name and middle initial.
3. The basic coverage (hospital, medical-surgical and ambulatory), as well as the dental, pharmacy and major medical coverage will apply according to what is established in the policy.
4. Optional dependents may choose similar or fewer services, but not more services than the main plan member. The Major Medical Coverage is not available for optional dependents. Optional dependents over age 65 are not eligible for pharmacy coverage.
5. To be eligible to Triple-S Salud Care Plus Coverage, the person must have Medicare Parts A and B. The person must submit the documents to evidence Medicare Parts A and B coverage and a copy of the Birth Certificate.
6. Hospital and Basic Medical Services offered in Esssencial Plans are only available for the employee; these plans do not cover optional dependents. Esssencial plans do not offer pharmacy coverages, major medical expenses, Care Plus and services in the United States. The hospital plan does not offer ambulatory services, except emergency room services.
7. Please be sure that the information you provide is complete and accurate. Sign and date the application.

OBSERVATIONS: _____

AUTOMATIC PAYMENT (Does not apply to COBRA)

CHECKING OR SAVINGS ACCOUNT

Type of account: ☐ Checking ☐ Savings

Bank ACH Routing Number (ABA)(9 digits)

Bank Account Number

Bank or Financial Institution name

Name as appears on Bank Account

Signature of Account Holder

Authorization code:

___ 03: Debit on the 4th of each month

___ 07: Debit on the 11th of each month

___ 09: Debit on the 19th of each month

___ 99: Debit on the 27th of each month

Note: 1.You should check your bank or financial institution with their requirements for an Electronic Debit (ACH Debit). 2.This application must include your first payment. 3.This service (Electronic Debit) will be effective as of the month after this completed application is approved by our company.

Applicable terms: 1. This authorization will be in effect until a client's cancellation letter is received, and reasonable time is given to the company and the bank to process the request. Said notice should be delivered in our offices, service centers or mailed to Triple-S Salud, Inc. Attn. Credit and Collection Department, P.O. Box 363628, San Juan, PR 00936-3628 or by fax at 787-774-4804 or 787-749-4197. 2. If any changes occur on the banking account, it is the client's responsibility to notify it with thirty (30) days in advance and complete a new Automatic Payment application. 3.The bank's monthly statement will serve as payment receipts. 4. Triple-S Salud, Inc. reserves the right to finalize this payment method and your enrollment in said system.

Important Note: If the bank account is not in the name of the insured, the holder of the account must sign this authorization.

PREMIUM PAYMENT

Both the Employer and the insured person will be jointly responsible for the payment of the policy's premium, provided that said responsibility will cover all premiums due until the policy's date of termination, in accordance with the policy's TERMINATION clause.

Triple-S Salud reserves the right to collect the premium due or, at its discretion, it may recover the costs incurred in the payment of claims for services rendered to the insured person after the cancellation of said person's health plan; provided that the insured person will be responsible for the payment of any of the two amounts claimed by Triple-S Salud, except for the provisions contained in the policy's Conversion Clause.

Triple-S Salud reserves the right to give a detailed report to any credit reporting agency, institution or organism on the default in payment by the employer or the insured person. Being also provided that the debtor shall bear legal costs, expenses and fees, as well as any other additional expense Triple-S Salud incurs to collect the debt.

Law number 18 of January 8, 2004 establishes that:

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

TRIPLE-S VIDA Payroll deduction authorization

I hereby authorize my employer _____ to deduct from my salary those amounts that are payable by me either now or at a later date for the plans acquired through Triple-S Vida, Inc. This deduction cancels any previous authorization for payroll deduction in respect of any similar insurance plan with the company: _____ for $_____.

Name of Employee _____ Social Security Number: _____

Signature of Applicant: _____ Deduction Authorized $ _____

Signature of Authorized Representative: _____ Number: _____ Date _____

COBRA LAW

By signing this application I commit to pay the premium required to ensure continuity of group benefits for me and my eligible dependents, if any, included in this application. I also understand that the amount of this premium may vary at any moment there is a change of status or when the group policy is renewed. I understand that the benefits under this coverage shall expire (1) once a period of 18 or 36 months has elapsed, as applicable; (2) if I do not pay the premium or ,(3) if my current eligibility status changes. Once the plan is cancelled for lack of payment or for other valid reason I know that I will not be able to enroll in the coverage herein provided. Even more, I know that this coverage may end if the coverage the employer offers to its active employees is cancelled. Enclosed with this application is the check or money order for the payment of the premium corresponding to the period from the coverage effective date to the month of _____.

EMPLOYER CERTIFICATION (COBRA)

I hereby certify that the person that subscribes this application is eligible to continue receiving the benefits of the group plan under the provisions of COBRA for a maximum of _____ months. The premium to be paid in order to receive these benefits is _____, subject to verification by the insurance company. We authorize said company to keep the applicant under our group coverage. We understand it is our duty, as employer, to deal the billing and collection process directly with the beneficiary and to pay the insurance the premium amount owed so the person can continue coverage under COBRA. Included is the corresponding premium payment, as previously calculated.

I HEREBY CERTIFY that the information in this application is accurate and true; that I have never, directly or indirectly, presented a fraudulent claim or any false evidence to support a claim with the purpose of obtaining a payment according to the insurance contract; and, I authorize Triple-S Salud to verify these facts and this information and to cancel my health insurance plan if what I hereby certify is not true.

In case the policy is cancelled, I will assume the responsibility of the health service costs rendered to any plan member insured under this policy, as of the cancellation date; and that by assuming this responsibility I do not limit Triple-S Salud's right to take any legal action against me as long as this legal action is initiated in conformance with the Law

GROUP NAME	GROUP NUMBER	SIGNATURE OF GROUP ADMINISTRATOR
NAME OF APPLICANT	SIGNATURE OF APPLICANT	DATE (MONTH/DAY/YEAR)