MCS Life Insurance Company
P.O. Box 9023547
San Juan, P.R. 00902-3547

SUBSCRIPTION FORM/CHANGE - INDIVIDUAL PRODUCTS

Please handwrite and use black ink to complete this form.

Name of the product selected: MCS Personal _____ Effective date requested: _____ (month/ day/ year)

Metalic Coverage: [ ] Bronze [ ] Silver [ ] Gold

Optional selected coverages: [ ] Dental 300 [ ] Dental 400 [ ] Life Insurance Waiting periods apply: [ ] Yes [ ] No

Select if you prefer another language, other than Spanish:
[ ] English [ ] Other:_____ Previous health plan: [ ] Triple S [ ] First Medical [ ] Humana [ ] Other [ ] Group [ ] Individual
Select if you want format: Braille [ ] Yes Electronic [ ] Yes
The contract is: [ ] Sale [ ] Product Change [ ] Inclusion [ ] Same product convertion Service Center: _____

Last Name	Mother's Maiden Name (Second) Last Name	Name	I.	Age

Date of birth (m m d d y y y y)	Gender	Social Security Number (Required)	Tobacco use*	Monthly Premium: Health: $_____ Life: $_____ **Total:** $_____
	[ ] M [ ] F		[ ] Yes [ ] No	

Mailing Address

Zip Code **P R**

Home Address

Zip Code **P R**

Check Type of Contract [ ] Ind. [ ] Couple [ ] Fam.	Authorized Representative's Code	Primary Insured's Email Address

Home Phone	Work Phone	Extension	Cell Phone	Payment Method** [ ] ACH [ ] L.C.

If you have another health plan, indicate company:	Type of coverage: [ ] Retiree [ ] COBRA [ ] Active employee	Type of policy other plan: [ ] Group [ ] Ind.

Policy Number / Contract	Other Policy Effective Date	Other Policy Contract [ ] Ind. [ ] Couple [ ] Fam	Other Policy Type of Benefit [ ]Medical [ ]Dental [ ]Pharmacy [ ]Vision

Have Medicare [ ]Yes [ ] No	Medicare Beneficiary Identifier (MBI)	Part A Effective Date	Part B Effective Date

PAYMENT AGREEMENT BY AUTOMATIC PREMIUM DISCOUNT

You have the option of choosing one of the two available automatic payment alternatives. To do this, complete the following information:

___ 1- Bank Account

Account type [ ] Savings [ ] Check	Routing and transit number	Account number

By this means I authorize MCS Life Insurance Company, to order monthly charges to my bank account for the premium payment of the contract in reference. The automatic discount will be done the 10th day of each month. To best identify your account, please send a void check (or its copy) of the account to be debited from. In case of a savings account, send copy of the identification that appears on the Monthly Account Statement. For each returned a $15.00 automatic discountcharge will apply for its handling and processing.

___ 2- Credit card

Card Type: ___ Visa ___ Master Card ___ AMEX	Card number	Expiration Date M M / Y Y

Authorized signature for the account _____

DIRECT DEPENDANTS (SPOUSE OR DOMESTIC PARTNER AND CHILDREN):

Last Name	Mother's Maiden (Second) Last Name	Name	I.	Age

Relationship (spouse or domestic partner/children)	Gender	Date of Birth (m m d d y y y y)	Social Security (Required)	Tobacco use*
	[ ] M [ ] F			[ ] Yes [ ] No

E-mail (over 21 years old)	Monthly premium: Health: $_____

Cell Phone (if dependant is over 21 years old)	Is your dependant employed?	Dependant employer	Does your dependant participates in the medical plan that his/her employer offers?
	[ ] Yes [ ] No		[ ] Yes [ ] No

Name of the health plan of your dependant employer	Number of policy/contract of employer's plan	Effective date of employer's plan Month ____ / Day _____ / Year _____	Contract type of employer plan [ ] Individual [ ] Couple [ ] Family

Is your dependant covered by Medicare? [ ] Yes [ ] No	Medicare Beneficiary Identifier (MBI) (Required)

Benefit of the employer's plan: [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Effective date of Part A: Month ___ / day____ / Year ___ Part B: Month ___ / day ___ / year__

Last Name	Mother's Maiden (Second) Last Name	Name	I.	Age

Relationship (spouse or domestic partner/children)	Gender	Date of Birth (m m d d y y y y)	Social Security (Required)	Tobacco use*
	[ ] M [ ] F			[ ] Yes [ ] No

E-mail (over 21 years old)	Monthly premium: Health $_____

Cell Phone (over 21 years old)	Is your dependant employed?	Dependant employer	Does your dependant participates in the medical plan that his/her employer offers?
	[ ] Yes [ ] No		[ ] Yes [ ] No

Name of the health plan of your dependant employer	Number of policy/contract of employer's plan	Effective date of employer's plan Month ____ / Day ____ / Year _____	Contract type of employer plan [ ] Individual [ ] Couple [ ] Family

Is your dependant covered by Medicare? [ ] Yes [ ] No	Medicare Beneficiary Identifier (MBI) (Required)

Benefit of the employer's plan: [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Effective date of Part A: Month ___ / day____ / Year ___ Part B: Month ___ / day ___ / year__

Last Name	Mother's Maiden (Second) Last Name	Name	I.	Age

Relationship (spouse or domestic partner/children)	Gender	Date of Birth (m m d d y y y y)	Social Security (Required)	Tobacco use*
	[ ] M [ ] F			[ ] Yes [ ] No

E-mail (over 21 years old)	Monthly premium: Health $_____

Cell Phone (over 21 years old)	Is your dependant employed?	Dependant employer	Does your dependant participates in the medical plan that his/her employer offers?
	[ ] Yes [ ] No		[ ] Yes [ ] No

Name of the health plan of your dependant employer	Number of policy/contract of employer's plan	Effective date of employer's plan Month ____ / Day ____ / Year _____	Contract type of employer plan [ ] Individual [ ] Couple [ ] Family

Is your dependant covered by Medicare? [ ] Yes [ ] No	Medicare Beneficiary Identifier (MBI) (Required)

Benefit of the employer's plan: [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Effective date of Part A: Month ___ / day____ / Year ___ Part B: Month ___ / day ___ / year__

*Tobacco use means tobacco use an average of four or more times per week within a period no longer than six months. Includes tobacco products, except tobacco use for religious or ceremonial purposes. Also, tobacco use is defined based on the last time the tobacco product was used. ** Payment Method: ACH - Automatic Discount / L.C. - Coupon Book.

DIRECT DEPENDANTS (SPOUSE OR DOMESTIC PARTNER AND CHILDRENS):

Last Name	Mother's Maiden (Second) Last Name	Name	I.	Age

Relationship (spouse or domestic partner/childrens)	Gender	Date of Birth	Social Security (Required)	Tobacco use*
	[ ] M [ ] F	m m d d y y y y		[ ] Yes [ ] No

E-mail (over 21 years old)	Monthly premium:	Health: $_____

Cell Phone (over 21 years old)	Is your dependant employed?	Dependant employer	Does your dependant participates in the medical plan that his/her employer offers?
	[ ] Yes [ ] No		[ ] Yes [ ] No

Name of the health plan of your dependant's employer	Number of policy/contract of the employer's plan	Effective date of employer's plan	Contract type of employer plan
		Month ____ / Day _____ / Year _____	[ ] Individual [ ] Couple [ ] Family

Is your dependant covered by Medicare? [ ] Yes [ ] No	Medicare Beneficiary Identifier (MBI) (Required)

Benefit of the employer's plan: [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Effective date of Part A: Month ___ / day____ / Year ___ Part B: Month ___ / day ___ / year__

Last Name	Mother's Maiden (Second) Last Name	Name	I.	Age

Relationship (spouse or domestic partner/childrens)	Gender	Date of Birth	Social Security (Required)	Tobacco use*
	[ ] M [ ] F	m m d d y y y y		[ ] Yes [ ] No

E-mail (over 21 years old)	Monthly premium:	Health: $_____

Cell Phone (over 21 years old)	Is your dependant employed?	Dependant employer	Does your dependant participates in the medical plan that his/her employer offers?
	[ ] Yes [ ] No		[ ] Yes [ ] No

Name of the health plan of your dependant's employer	Number of policy/contract of the employer's plan	Effective date of employer's plan	Contract type of employer plan
		Month ____ / Day _____ / Year _____	[ ] Individual [ ] Couple [ ] Family

Is your dependant covered by Medicare? [ ] Yes [ ] No	Medicare Beneficiary Identifier (MBI) (Required)

Benefit of the employer's plan: [ ] Medical [ ] Dental [ ] Pharmacy [ ] Vision	Effective date of Part A: Month ___ / day____ / Year ___ Part B: Month ___ / day ___ / year__

A 90 days waiting period will be applied (except for emergency services) to all cases enrolled outside the Annual Enrollment Period or outside the Special Enrollment Period as a result of a situation not related to a qualifying event according to the Health Insurance Code of Puerto Rico, and the applicable regulations issued by the Office of the Commissioner of Insurance of Puerto Rico (OCI).

LIFE INSURANCE FOR DEATH ($25,000 if you choose the additional option of life insurance):

The Life Insurance benefit for death will be available for the principal insurer older than 18 years old and under 65 years old, provided the additional option of life insurance is chosen.

Beneficiary Information:

Write the names of the persons who will receive the insurance benefit and the percentages (Total must be equal to 100%)

Beneficiaries (Name and two Last Names)	Quantity	Beneficiaries (Name and two Last Names)	Quantity
1		3	
2		4	

POLICY TERMS

I acknowledge and certify that I have completed all the responses on this form related to myself and/or my eligible dependants truthfully and accurately to the best of my knowledge and that no material information has been omitted on an intentional or negligent manner. I understand and agree that my authorized insurance representative has no authority to waive answers or required information totally or partially, promise insurability, alter any contract and/or waive information regarding any individual health insurance regulation in Puerto Rico. I further agree that no insurance will be effective until the date the policy is accepted by MCS Life Insurance Company (MCS Life) and a written notification is given to me. In case of receiving an incomplete application, the information will be valid for a maximum of 60 days from the date of signature.

MCS Life reserves the legal right to require any necessary document to complete the subscription requirements including, but not limited to birth certificate, letter or prior insurer certificate that may be required by Law, among others. MCS Life could request the applicant of a health plan to complete a medical questionnaire to submit information about conditions he/she suffers, medications he/she takes, and care he/she receives to keep under control his/her health condition, just like information about the primary physician who takes care of the condition. The information in this questionnaire will be used only and exclusively for the insurer to enroll the insured person in established disease management programs.

I understand the policy applied for is not an employer-sponsored group health plan and it does not comply with federal small employer laws. I certify that I do not qualify for or have willingly waived a group health plan or receive favorable tax treatment under federal or Puerto Rico laws.

I certify I have read this document or it has been read to me. I understand that if I do not request coverage for any of my eligible dependants or if I waive to participate from a health plan because I am covered by another health insurance plan and at a later date request to join or request to add any of my eligible dependants, I will be subject to all terms and conditions of the policy and/or applicable regulation.

I acknowledge that I have been provided with a notice of my Privacy Rights, which provides a complete description of how my protected health information may be used or disclosed.

Any person who knowingly and with intent to defraud MCS Life, submits an application or files a claim containing any materially false information or misstatements, that information may be used to deny a claim, terminate or void coverage if such information materially affects the degree of risk. This provision will be in effect provided that the omitted or falsely stated fact is the direct cause of the loss claimed to the insurer. In accordance with the provissions of Law No. 230 from August 9, 2008, provides the following:

"Any person who knowingly and with the intent of defrauding presents false information in an insurance application or, who submits, helps, or forces to submit a fraudulent claim for the payment of a loss or other benefit, or submits more than one claim for the same damage or loss, will incur in a criminal offense and if convicted, will be punished, for each violation, with a fine of no less than five thousand dollars ($5,000), and no greater than ten thousand dollars ($10,000), or with a fixed prison term of three (3) years, or both penalties. If there are any aggravating circumstances, the established fixed penalty term may be increased up to a maximum of five (5) years; if there are any extenuating circumstances, it may be reduced to two (2) years".

In case of identifying some situation of potential fraud, abuse, money waste and/or lack of compliance, you can call 1-877-627-0004 or access mcs.com.pr. The call is confidential and can be done anonymously.

The answers expressed in this application form part of it as if they were included on the signature of the principal applicant below. According to article 27.170 of Act No. 230 of August 9, 2008, as amended, known as False Reports and Declarations to obtain insurance: (1) No person may render, present, offer, participate or help render, present or Offer any document, data, statement or report that is false to obtain an insurance policy and (2) any person who knowingly incurs the acts described above shall be deemed to have committed fraud for the purposes of this chapter. If MCS Life determines that there was fraud or intentional misrepresentation of a material fact, as prohibited by the terms of the plan or policy, it will proceed to cancel the policy automatically and to recover any amount paid for services rendered. I acknowledge that if the policy is canceled, I will assume responsibility for the cost of the services that are unduly rendered to any of those insured by the policy as of the date of cancellation.

If you wish to make any change in your payment method, contact our Customer Service Call Center Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturdays from 8:00 a.m. to 4:30 p.m. at 787-281-2800 metro area or at 1-888-758-1616 or visit our Service Centers.

I certify that I read or the information offered by me in this application was read to me, that it is true and complete. A copy will be as valid as the original.

MATERIALS SUBMISSION AUTHORIZATION BY EMAIL AND RECEIPT OF TEXT MESSAGES

By providing on this subscription sheet your email address or mobile number and / or that of your dependents (over 21 years of age), I expressly authorize MCS Life or its affiliates, by itself or through a third party, for voluntarily sending and receipt of marketing and educational material, policy, notices and documents, except as provided in Art. 14,140 (C) (1) (2) of the Health Insurance Code, to the address (s) or telephone (s) provided , including by text message (SMS or MMS). Through this agreement, you acknowledge that MCS or its subsidiaries do not charge for these services. However, some charges for the receiving and sending of emails and/or text messages may apply according to the contract with your telephone service provider or data mobile. For more information on the applicable charges you should contact your service provider. This consent means continuous and uninterrupted and the effectiveness of your policy does not depend on it. MCS Life will not cancel, refuse to issue or renew a policy if you refuse consent for electronic delivery. To receive the policy electronically, it is necessary to have access to the technological equipment where you can access an email with the basic programs.You should contact our Customer Service Call Center for any of the following: you do not wish to receive or continue to receive communications via email and / or text message, request to receive a printed copy of the policy, notices and documents free of charge, by mail at 787.281.2800 metro area or 1.888.758.1616 or visit one of our Service Centers to request a printed copy of the aforementioned documents free of charge, update the data related to your method of preference for sending information and/or follow the specific instructions included in each communication. You will receive, among other documents, the Notice of Privacy Practices and a quarterly notification of the availability of the Explanation of Benefits (EOB) report in MCS Life web page at mcs.com.pr. Only the primary insured can access the EOB of the dependants under 21 years old.

I also understand that the fee or monthly premium will be set according to the age of the policy holder and each of their dependants at the time of the renewal, and to the smoker or non-smoker status, as reported by them to MCS Life pursuant the provisions of the PPACA and Health Insurance Code of Puerto Rico. If changes in the smoker or non-smoker status occur, the insured person is responsible and has the obligation to notify the change in writing to MCS Life through Medical Certification. I also understand that the health coverage involves a payment responsibility that should be paid every 1st day of each month and if by any reason this doesn't happen, MCS Life will determine, based on the grace period, according to Article 7 of Law No. 161 from 2010, the cancellation of the coverage for payment failure.

I hereby certify that the Authorized Representative, indicated below, explained to me and I understood the waiting periods (90 days) that apply to the Policy.

I also certify that I received from him/her the Summary of Benefits and Coverage (SBC) of the product applied for in this formulary and that I was informed about my rate and those of my dependants, as included in this document. Cancellation or termination of an insurance policy or contract or the benefits of a health or life insurance policy will be mailed to the primary insured.

Printed name of primary applicant	Printed Name of payer (if other than applicant)
Signature of primary applicant	Signature of payer
Date	Payer´s Social Security (Required)
	Date

Authorized Representative:

Authorized Representative´s Name	Authorized Representative´s Code	Signature	Date

Applicant´s or Authorized Representative´s Comments _____

PATIENT´S RIGHTS AND RESPONSIBILITIES ACT NOTICE
WRITTEN RESPONSIBILITY WAIVER

I, _____, will comply with the obligations established under Article 16 of Act No. 194 of August 25, 2000, which reads as follows: Every insured person is required to become familiarized with the “Patient’s Rights and Responsibilities Act” or an adequate and reasonable summary of said Act, as prepared and authorized by the Department of Health. As proof of compliance with such requirement, prior to signing any contract, every insured person is required to sign a written statement or waiver certifying that he/she was supplied with, read, and was familiarized with the “Patient’s Rights and Responsibilities Act” or with the summary approved by the Department of Health. If you have any questions or need guidance on your rights or responsibilities please contact the Oficina del Procurador de la Salud at 787-977-0909 or the Insurance Officer at 787-304-8686 to ask for help at any moment. Through this means, I hereby waive/release MCS Life Insurance Company from any liability that may arise from my non-compliance with what is provided in this document and in Article 16 of Act No. 194 of August 25, 2000.

I received an adequate and reasonable summary of the Patient’s Rights and Responsibilities Act and the Privacy Practices Notice.

Authorized Representative’s Name	Main Insured's Name
Authorized Representative’s Signature	Main Insured's Signature
Authorized Representative’s Code	Date of waiver

CONFIDENTIALITY NOTE

This formulary contains privileged and confidential information for exclusive use of the person or entity it addresses. If you receive it by mistake, you are not authorized to review, disclose, spread, distribute or photocopy it. If you received this information by mistake please notify inmediately at 787-758-2500 to make arrangements to return or destroy the documents.

INSURED RIGHTS

- To receive high quality health services.
- To be treated with respect and to acknowledge your right to dignity and privacy.
- To receive information from your physician, as well as participate in all decisions related to your medical care including the rejection of medical treatment.
- To receive from your physician all the information related to your condition, available treatment options and their costs.
- To discuss medically necessary treatment options for your condition, regardless of the cost or if the service is covered.
- Your healthcare provider shall respect and obey your decisions and preferences regarding your treatment.
- To receive orientation from your physician about advanced directives or guides of your preference and the method to establish them. To make use of these directives or guides for your medical treatment.
- To choose the medical group, primary care physician, specialist, laboratory, pharmacy and x-rays of your choosing, that are included in the health care provider list of MCS Life Insurance Company.
- To change the IPA or primary care physician following the processes established by MCS Life Insurance Company.
- Your medical information shall be kept under strict confidentiality by your healthcare providers, in accordance with to the privacy standard of the HIPAA Act.
- Subject to any premium payment requirement, in case of cancellation or termination of a plan or provider, the patient may continue to receive the benefits of said plan during a transition period of ninety (90) days, counting from the termination date of the plan or provider. The patient has the right to be notified by the entity about said termination or cancellation, with thirty (30) calendar days before the date of termination or cancellation.
- In the cases of termination or cancellation of a patient who is hospitalized at the time of the termination date of the plan, and the discharge date has been programmed before said termination date, the transition period will be extended from this date until ninety (90) days after the date in which the patient is discharged.
- In the cases of termination or cancellation of a female patient who is in the second trimester of her pregnancy at the moment of the plan termination and the provider has been offering medical treatment related to the pregnancy before the termination date of the plan, the transition period regarding the services related to the pregnancy will be extended until the discharge date of the mother from the hospital due to the delivery or the discharge date of the newborn; of the two, whatever happens later.
- In the case of a patient diagnosed with a terminal condition before the termination date of the plan, and the provider has been offering medical treatment related to that condition before the termination date, the transition period will be extended during the remaining time of the patient's life.
- To be treated in any Emergency Room in Puerto Rico 24 hours a day, 7 days a week, without the need for authorization from your primary care physician or insurer.
- To receive equal, considerate and respectful treatment from all members of the healthcare industry.
- No patient will be discriminated against because of the private or public nature of facilities or because of any consideration of race, color, gender, age, religion, national or ethnic identity or origin, political ideology, future or present mental or physical disability, genetic or medical information, social condition, sexual orientation or payment ability or form of payment of the user or consumer of said services and facilities.
- Every provider, physician-hospital institution and every insurance entity will provide to every patient speedy access to his or her files and records. The patient has the right to receive a copy of his or her medical record in a period not exceeding five (5) days, in the cases in which the medical file is requested to a physician-hospital institution, this file shall be delivered in a term no greater than fifteen (15) working days, through the payment of a reasonable cost which shall not exceed seventy-five (.75) cents per page up to a maximum of twenty-five (25) dollars per medical record.
- To have simple, just and efficient procedures or mechanisms available to solve the differences with their healthcare plans and any medical care facility or professional and also to have available a way of appealing any decision.
- To find adequate medical services for your condition in an easy manner.
- To receive medical services when you requested them and for them to be medically necessary; that they be included in your benefit coverage.
- No health insurance plan may impose gag clauses to their physician-hospital health service providers or penal clauses or other contractual mechanisms that interfere with the ability or capacity of providers to communicate with said insured and beneficiaries about available treatment options.
- To file a grievance before MCS Life Insurance Company at any moment that you may feel dissatisfied with the services you are receiving. You should refer to the back of your card where you will find the phone number of Customer Service.
- To contact the Oficina del Procurador de la Salud at 787-977-0909 or with the Commissioner of Insurance at 787-304-8686 to ask for help at any moment.
- The right to request a receipt for incurred expenses or that it be provided for the payment, partial and/or total, of deductible or others, at the moment of making the payments, including, as a minimum the name of the facility or service provider, license number and specialty, date of rendered service, name of patient, name of person paying the services if it is not the patient, amount paid per service, and signature of the officer authorized by the facility or provider.
- To receive services from a specialist per the list of MCS Life Insurance Company providers according to the referral procedures of your health plan.
- To read your contract or booklet of coverage benefits.

INSURED RESPONSIBILITIES

- To provide your physician with health information as complete and exact as possible, about your current health condition, prior illnesses, medicine, hospitalizations and other related issues.
- To inform your physician of the unexpected changes in your health condition.
- To provide a copy of your advanced directives or guides in writing, if they exist, of your wishes to receive or not receive medical treatment in order to prolong your life.
- To keep yourself in a good state of health by calling and visiting your primary care physician.
- To follow the medical treatment agreed by your physician.
- To inform your health professional if you anticipate problems in the prescribed treatment.
- The patients are responsible for recognizing the impact that their lifestyle is having on their personal health and assume the initial personal responsibility for their own health and care.
- To participate in all decisions related to your health care.
- To provide the necessary information about health plans and to collaborate with the provider regarding your respective financial arrangements when it is necessary to pay in a timely manner all accounts and bills sent to you.
- To inform if you have another health plan.
- To inform the authorities about any improper action or fraud that you have knowledge of in regards to the physician-hospital health facilities and services.
- Responsibility to comply with the operational and administrative procedures of your health plan, health services provider, and the government health benefit programs.
- To be informed of the type of coverage, options, benefits, limits, exclusions, referrals and grievance filing, review and solution procedures of your health plan.
- To pay the assigned deductible, as indicated on your card.
- To respect that the services of this plan are for the person enrolled. The unlawful use of the MCS Life Insurance Company Health Card is prohibited by law.
- To respect the enjoyment of other people at the service offered in health facilities.
- The patients, their family members and companions are responsible for making the corresponding arrangements so that the needs of the hospital, of other patients, of the medical faculty, and other employees are not affected by your particular actions.
- To recognize the risks and limits of medicine and the possibility of a mistake from the health professional.
- To not show immoral behavior or alter the peace in the health facilities.

MCS Life Insurance Company
P.O. Box 9023547
San Juan, P.R. 00902-3547

RECEIPT ACKNOWLEDGMENT

Application date: _____

Applicant name: _____

Applicant telephone number: _____

Product applied for: _____