TRIPLE-S SALUD

Independent Licensee of Blue Cross Blue Shield Association

PO Box 363628
San Juan, PR 00936-3628
Tel. 787-774-6060

Group Enrollment Application

TS Óptimo+ | ✔ Optimo Reserve | Other _____
Triple-S Empresarial | Cobra Law
Pocket by Triple-S | Associations

This form must be received on or before 10 days before the effective date.

FILL IN ALL PARTS OF THE APPLICATION ON BOTH SIDES / INCOMPLETE APPLICATIONS WILL BE RETURNED WITHOUT PROCESSING

Social Security Number	Effective On Month Day Year	Sponsor S P	Org Policy

Group Name: UKPEAGVIK INUPIAT CORPORTION - BOWHEAD MARINE SUPPORT SERVICES

This contract is: ✔ NEW | CONVERSION | RENEWAL _____ | INDIVIDUAL | COUPLE | FAMILY

MAIN INSURED

Last name (s), First Name, Middle Name	Marital Status	Gender F M U	Date of Birth Month Day Year

Physical Address	Employee number according to paycheck

City	Country / State	Zip Code 0 0	License number or member number (only for colleges and associations)

Postal Address	E-mail (to receive personal information):

City	Country / State	Zip Code 0 0

Position	Date of Employment Month Day Year	Mobile Phone	Home Phone	Work Phone

Optional Benefits requested for yourself and your direct dependents

✔ BASIC ✔ PHARMACY_____ ✔ DENTAL_____ ✔ PAE ✔ MAJOR MEDICAL ✔ ORGAN TRANSPLANT ✔ LIFE INSURANCE /AD&D 10,000 TRAVEL ASSISTANCE

Do you have another Health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Name of Plan: _____ Medicare Number:_____

Contract Number:_____ Tobacco Smoker Yes No

Tobacco use: Defined as the use of a tobacco product or products four or more times per week within a period not exceeding the past 6 months by legal users of tobacco products and includes all tobacco products.

DIRECT DEPENDENTS

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

OPTIONAL DEPENDENTS

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number
N/A				

BASIC | PHARMACY | DENTAL | SUPPLEMENTAL | OTHERS_____

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number
N/A				

BASIC | PHARMACY | DENTAL | SUPPLEMENTAL | OTHERS_____

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

Last name (s), First Name, Middle Name	Relationship	Date of Birth Month Day Year	Gender F M U	Social Security Number
N/A				

BASIC | PHARMACY | DENTAL | SUPPLEMENTAL | OTHERS_____

Do you have another health plan? Yes No Do you have Medicare? Yes No Date Part A:_____ Date Part B:_____ Tobacco Smoker Yes No
Name of Plan: _____ Medicare Number: _____

CONVERSION

Prior Triple-S Salud contract number, if this contract is a conversion.	CONVERSION Month Year

DEATH LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Life Insurance Benefit for death, Accidental Death and Dismemberment Insurance will be available to the main insured.
BENEFICIARY INFORMATION (To file a claim, please contact at (787) 758-4888 or by email to servicio@sssvida.com.) Write the name(s) of the people who will receive your Insurance benefit, your relationship, and the percentage allocated (percentages must total 100%).

BENEFICIARY (NAME AND BOTH LAST NAMES)	RELATIONSHIP	AMOUNT (%)

NAME: _____ SOCIAL SECURITY NUMBER: _____

PREMIUM PAYMENT

Your Triple-S Health insurance policy is prepaid. Each invoice expires on the first day of the month being billed with a 30-day grace period. A longer delay in this grace period may affect the validity of your policy. Triple-S Health offers several payment alternatives such as automatic checking or savings account debit, ACH payment and wire transfer. For these payment alternatives you can contact your Sales Representative.

Both the employer and the insured employee shall be jointly responsible for paying the policy premium; providing that such responsibility covers the entire premium due until the policy's date of termination, according to the clause of Termination of the policy.

Triple-S Salud is entitled to collecting the premium due or, at its option, it may recover the costs incurred in the payment of claims for services provided to the member after the cancellation of that person's health plan; stipulating that the insured employee shall be responsible for paying any of the two amounts as claimed by Triple-S Salud, except for the provisions contained in the conversion clause of the policy.

Triple-S Salud reserves the right to alert any credit agency, institution, or entity, in detailed form, about the breach of payment incurred by the employer or insured employee. Besides, the debtor shall be required to pay the costs, expenses, and attorney fees, as well as any other additional amount or expense that Triple-S Salud incurs to collect any debt.

Authorized representatives may receive monetary compensation based on your affiliation, among others. This does not change the premium (cost) or benefits of the plan you selected.

Initials: _____

COBRA LAW

COBRA LAW

Reason to request COBRA law: ___ Resignation Dismissal Retirement Employee enrolled in Medicare Dead Divorce Not eligible as a dependent Other _____

Date of Notification to Employer	COBRA Law Effective Date	Date of the Event	Requested by
Month Day Year	Month Day Year	Month Day Year	Employee Direct Dependent

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) after the COBRA or USERRA law extended period coverage ends, 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 LAW)

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 _____monthly, 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 with this application is the corresponding premium payment, as previously calculated. The employer and the COBRA administrator, if any, must report the monthly payments made by each person under COBRA, the amount of persons in grace period for non-payment of COBRA premium and the estimated date on which the employer intends to terminate the plan of the person covered under this law due to non-payment of premiums.

CONSENT FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

☐ I consent to Triple-S Salud sending me notices, bills, reports, replies to information requests, grievances, policies, provider directories, drug list, SBCs, or any other information materials about the plan to the email address provided in this application by secured electronic methods. I understand that Triple-S Salud will send the document so I may print it and save it for future reference. I understand that, with this consent: 1. I do not lose the right to obtain the information on paper, if I request it, free of charge, in accordance with Rule 102 of the CSPR Regulations,; 2. I am responsible for keeping all of my contact information up to date; 3. Whenever necessary, Triple-S Salud will notify me of any change to the equipment or application requirements needed to access or retain the that are necessary to access or retain the electronic documents or information set to me.4. By providing in this application form the email address or phone number and/or that of your dependents (over 21 years of age), I expressly authorize Triple-S Salud and/or its subsidiaries, by itself or through a third party, to send and receive promotional or educational material to the address(es) or telephone number(s) provided, including text message (SMS or MMS). By this consent, you acknowledge that Triple-S Salud or its subsidiaries do not impose a charge for this service. However, certain charges for receiving and sending emails and/or text messages may be applicable in accordance with the contract with your mobile phone or data service provider. For more information on applicable charges, you should contact your service provider. This consent shall be understood to be continuous and uninterrupted. 5. I provide this authorization recognizing the potential risk of unauthorized disclosure by having the information available on my device (email or text box), the lack of security controls on my device, among other risks associated with the way I access or handle the information shared with me that could affect the privacy and security of my information.

I may revoke this consent at any time via notice to the Customer Services Department of Triple-S Salud specifying, at least, my full name, contract number, and effective date of the revocation. Initials: _____

AUTHORIZATION

By completing this application and enrolling in the Triple-S Salud medical plan, you authorize us to use and disclose your protected health and demographic information for the following activities that are inherent to our operation, including, but not limited to: underwriting , service coordination, evaluation and quality improvements, case and condition management programs, audits of clinical records and service utilization, fraud investigations, reinsurance, resolution of complaints and grievances, administration, payment and adjustments of claims, exchange of information with business partners that administer services and coverage on behalf of Triple-S Salud and with health service providers that provide services. The authorization is valid for as long as you are enrolled in the health plan. I can revoke this consent at any time by communication to the Triple-S Salud Customer Service Department in which I specify, as a minimum, my full name, contract number and effective date of the revocation. You can call (787) 774-6060, Service Line (toll free) 1-800-981-3241 during the following hours: Monday to Friday from 7:30 am to 8:00 pm, Saturday from 9:00 am at 6:00 pm and Sunday from 11:00 am to 5:00 pm.

INSTRUCTIONS

All shaded sections are for use by Triple-S Salud only. Be sure to read the Certificate of Benefits carefully.

1. Complete this application in ink, in print. Complete all the boxes, except the shaded sections.
2. All names must be spelled as follows: last name, first name and middle initial.
3. Your Social Security number is required for identification purposes. Triple-S Salud has implemented technical, physical and administrative safeguards to protect your information. It is only disclosed when permitted or required by state and federal law and in accordance with Law No. 207 of September 27, 2006.
4. The basic coverage (hospital, medical-surgical and ambulatory), as well as the optional coverages, Transplant and Life Insurance apply according to what is established in the policy.
5. The benefits and services covered under the basic coverage as well as its endorsements apply in accordance with the provisions of the policy.
6. To be eligible for Triple-S Salud Complementary coverage (Care Plus), the person must be covered by hospital and medical insurance under Medicare (Part A and Part B). Please attach a document that proves this and a copy of the Birth Certificate.
7. Make sure the information you provide is correct and complete. Sign and date the application.

ANTI-FRAUD NOTICE (ACT NO. 18 OF JANUARY 8, 2004, AS AMENDED)

Any person who knowingly and with intent to defraud presents false information in an insurance application or knowingly presents, assists or causes to be presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same loss or damage, commits a felony and, upon conviction thereof, shall be punished for each violation by a fine of not less than $5,000 nor more than $10,000 or imprisonment for a fixed term of three (3) years, or both penalties. Should there be aggravating circumstances, the penalty established may be increased up to a maximum of five (5) years; should there be attenuating circumstances, it may be reduced to a minimum of two (2) years.

ACKNOWLEDGEMENT

I CERTIFY that the information provided by me in this application is accurate and true; that I 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. Triple-S Salud may end its contract retroactively due to fraud or intentional misrepresentation of substancial facts by the insured or the person applying for a health plan on behalf of someone else.

If the policy is cancelled, I will be responsible for the cost of the health services provided to any of the members insured by the policy as of the date of cancellation; 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.

UKPEAGVIK INUPIAT CORPORTION - BOWHEAD MARINE SUPPORT SERVICES		
GROUP NAME	GROUP NUMBER	SIGNATURE OF BENEFIT ADMINISTRATOR
NAME OF APPLICANT	SIGNATURE OF APPLICANT	DATE (MONTH/ DAY/ YEAR)

IMPORTANT NOTICE FOR PEOPLE WITH MEDICARE
THIS INSURANCE IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may result in benefits being paid of this policy.

This insurance provides limited benefits, if you meet the conditions of the policy, for hospital or medical expenses only when you are treated for one of the illnesses or health conditions listed in the policy. No pays your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.
These include:

- hospitalization
- medical services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

This policy must pay benefits regardless of any other health benefit coverage to which you may be eligible under Medicare or other insurance.

Triple-S Salud, Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina a base de raza, color, origen de nacionalidad, edad, discapacidad o sexo. Triple-S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 787-774-6060, (TTY/TDD), 787-792-1370 or 1-866-215-1999. Free of charge 1-800-981-3241. If you are a federal employee or retiree call 787-774-6081, Toll free 1-800-716-6081; (TTY/TDD) 787-792-1370; Toll free 1-866-215-1999. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 787-774-6060, Libre de costo 1-800-981-3241. (TTY/TDD) al 787-792-1370 o 1-866-215-1999. Si es empleado o retirado federal llame al 787-774-6081, libre de costo 1-800-716-6081; (TTY/TDD) 787-792-1370; libre de costo 1-866-215-1999. Independent Licensee of BlueCross BlueShield Association.