TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico
Concesionario Independiente de Blue Cross Blue Shield Association

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

Group Enrollment Application

☐ Óptimo Plus: Product __________ ☐ Óptimo Reserve ☐ Cobra Law
☐ Pocket by Triple-S ☐ Associations ☐ Other__________

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	Org Policy
		S P	

Group Name

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 ☐ MAJOR MEDICAL ☐ ORGAN TRANSPLANT ☐ LIFE INSURANCE / AD&D ☐ OTHERS__________________

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:______________________

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: ________ 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: ________ 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: ________ 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: ________ 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

☐ 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: ________ 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

☐ 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: ________ 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

☐ 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: ________ 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 DISMEMBER 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 NUMER: _____

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.

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 lists, SBCs, or any other information materials about the plan to the email address provided in this application through secured electronic methods. I understand that Triple-S Salud will send the document so I may print 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; 2. I am responsible for keeping all 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 electronic documents or information sent to me.
I may revoke this consent at any time via notice to the Customer Service 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 health plan, you authorize us to use and disclose your protected health and demographic information for the following activities, which are inherent to our operations, including but not limited to: enrollment, services coordination, quality assessment and improvements, case and condition management programs, audits of clinical records and service usage, fraud investigations, reinsurance, complaint and grievance resolution, administration, claim payments and adjustments, information exchange with business partners who provide services and policies on behalf of Triple-S Salud and with health service providers who provide services to you, sharing information with credit agencies, and business planning. This authorization will be valid for the time period during which you are enrolled in the health plan. This consent may be revoked at any time by communicating with Triple-S Salud's Customer Service Department in which you have to specify at least your full name, contract number and effective date of the revocation.

INSTRUCTIONS

All shades sections are the soles use of Triple-S Salud. Please be sure to read the Certificate of Benefits carefully.
1. Please handprint in ink the information in this application. Fill in all the blocks in the application, except those that are shaded.
2. All names must be written as follows: last name, name and middle name.
3. Your Social Security number is needed for identification purposes. Triple-S Salud has technical, physical and administrative mechanisms to protect your information. It will only be disclosed whenever allowed or required by state or federal laws and in compliance with Act no. 207 of September 27, 2006.
4. The basic coverage (hospital, medical-surgical and ambulatory) as well as the dental, pharmacy and major medical coverages will apply according to what is established in the policy.
5. Optional dependents may choose similar or fewer services, but not more services than the main insured. The major medical coverage and the organ transplant coverage are not available for optional dependents.
6. 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 copy of the Birth Certificate.
7. Please be sure that the information you provide is complete and accurate. Sign and date the application.

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

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 no less than $5,000 and no more than $10,000, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, 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.

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

NOTICE: INFORMING INDIVIDUALS ABOUT NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS AND NONDISCRIMINATION STATEMENT: DISCRIMINATION IS AGAINST THE LAW

Triple S Salud, Inc. complies with applicable federal civil rights laws and does not discriminate, exclude people or treat individuals differently because of race, color, national origin, age, disability, or sex.
Triple-S Salud, Inc.

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters,
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as :
  - o Qualified interpreters,
  - o Information written in other languages.

If you need these services, contact a customer a Service Representative.

If you believe that Triple S Salud, Inc. has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Service Representative
PO Box 363628, San Juan, PR 00936-3628
Telephone: (787) 749-6060 or 1-800-981-3241
TTY: (787) 792-1370 or 1-866-215-1999
Fax: (787) 706-2833
E-mail: TSACompliance@sssadvantage.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Service Representative is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically, through the Office of Civil Rights Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:
200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
Telephone: 1-800-368-1019, TDD: 1-800-537-7697

Call the customer service number on your ID card for assistance.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке,для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、IDカードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماس بگیرید.