Edificio **MAPFRE**
Urb. Tres Monjitas Industrial
297 Ave. Carlos Chardón, **San Juan** PR 00918-1410

PO Box 70297, **San Juan** PR 00936-8297

T 787.622.7780 **T** 1.888.835.3634 **F** 787.622.7775 **W** www.mapfrepr.com

MAPFRE | HEALTH

GROUP INSURANCE
Employee Transaction

__ Additions (Section B) __ Reinstatement (Section B) __ Changes (Section D) __ Termination (Section E) __ Cobra (Section F)

Complete in Ink

Section A: General Information

Employer Name	Contract Number	Division

Employee Name	Social Security	

Section B: Employee Information

Postal Address:			**Date of Birth**	**Month**	**Day**	**Year**	
Occupation:		**Date Employed (m/d/y):**		**A**			
Home Phone		**Work Phone / Ext**		**E-Mail Address**			
Sex:	__ Male	__ Female	**Marital Status:**	__ Single	__ Married	__ Widowed	__ Divorced/Separated

E.D. (M/D/Y-For MAPFRE Life Use)		**Please indicate if you or your dependents are covered by another plan**	__ Yes Complete (a)-(d)	**(a) Insurance Company Name** / **(c) Policy Number**
				(b) Employee Name / **(d) Policy Type**
			__ No	

Type of Coverage:	__ Single	**Type of Benefit:**	__ Health
	__ Employee/Spouse		__ Dental
	__ Employee/Child		__ Vision
	__ Family		__ Life & AD & D
			__ Optional Life & AD & D
			__ Prescription

I.C. (For MAPFRE Life Use)

Eligible Dependent Information

Name of all Eligible Dependents	Sex M/ F	Relationship	Birth Date (m/d/y)	Social Security	Residing out of Employee Home Y/N

Life Insurance Beneficiaries

Name of all Beneficiaries	Social Security	Birth Date (m/d/y)	Relationship	Benefit	Address of Beneficiaries

__ I reserve the right to change the beneficiary appointed above subject to any statutory restrictions. If the Group Insurance plan provides that contributions be made by me, I authorize my Employer to deduct them from my pay.

Employee Signature	**Date (m/d/y)**	**Witness Signature** (Must be of legal age or over and someone other than beneficiary)	**Date (m/d/y)**

GIET 11-06

Section C: Employer's Information

Employer Statement- this employee has been continuously employed by me since the date of the employment shown and is presently working on a permanent, active and full pay basis, which is not less than 30 hours per week. (For the number of hours otherwise stated in the group policy.)

Employer Signature	**Date (m/d/y)**

Section D: Change Information

Reason for Changes:	__ Marriage (complete Section A line 18)	**Date (m/d/y):**		
	__ Birth of Child (Complete Section A line 18)	**Date (m/d/y):**		
	__ Changes of Employee's Name	**New Name:**		
	__ Common Law Spouse (complete Section A line 18)	**Date (m/d/y):**		
	__ Divorce	**Are children still covered?**	__ Yes	__ No
	__ Change of Beneficiary (Complete Section A line 19)			
	__ New Wage	**Date (m/d/y):**		
	__ New Division	**Date (m/d/y):**		
	__ Other (Specify):			

FRAUD WARNING

Any person who knowingly and with the intention to commit fraud provides false information in an insurance application, or submits, helps or causes the submission of a fraudulent insurance claim for the payment of a loss or any other benefit, or submits more than one claim for the same damage or loss, will incur in a felony and, upon conviction thereof, shall be punished, for each violation, with a fine not less than five thousand (5,000) dollars, not greater than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravating circumstances are present, the fixed penalty established could be increased up to a maximum of five (5) years; if attenuating circumstances are present, the penalty could be reduced to a minimum of two (2) years.

I certify that the information on page one and two is complete and correct.

Employee Signature	**Date (m/d/y)**

Section E: Termination

_____ Date of Termination of Employment. *Please inform the postal address(complete Section B)	

Section F: COBRA

_____ Cobra (Please submit the Application for Continuation Under COBRA)	**Date (m/d/y):**	

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MAPFRE | SALUD

AUTORIZACION DE PAGO DIRECTO / DIRECT PAYMENT AUTHORIZATION

Nombre del asegurado(a) / Insured Name: _____

Número de grupo / Group number: _____ División / Division: _____

Correo electrónico / Email: _____

Número de teléfono / Telephone number: _____

Número de teléfono celular / Cell phone number: _____

Autorizo a enviar mensajes de texto(2) / I authorize to send text messages(2) : Si / Yes ____ No ____

Indique el día que desea se ejecute el débito / Indicate the day that you want your account to be debited : _____

___Débito bancario / ACH

Nombre del Banco / Bank Name: _____

Número de Ruta / Routing or ABA Number: _____

Dueño de la cuenta bancaria / Bank Account Owner: _____

Número de Cuenta / Account Number: _____

Tipo de Cuenta / Account Type: ___ cuenta de cheque / check account (incluir cheque anulado / Include void check) ___ cuenta de ahorro / savings account (incluir copia de estado de cuenta / Include bank statement copy)

___Tarjeta de crédito / Credit card

Tipo de tarjeta de crédito / Credit card type: ___ VISA ___ AMEX ___ MasterCard

Dueño de la tarjeta de crédito / Credit card owner: _____

Número de tarjeta de crédito / Credit card number: _____

Fecha de vencimiento / Expiration date (MM/YYYY): _____

Autorizo a MAPFRE Puerto Rico(1) a que comience con el trámite de débito electrónico a mi cuenta bancaria o tarjeta de crédito. Tengo conocimiento que la realización de las transacciones de ACH a mi cuenta o transacciones de tarjeta de crédito deben cumplir con las disposiciones de las Leyes Federales.

MAPFRE Puerto Rico se reserva el derecho de rehusar o cancelar los servicios de pago por vía electrónica. Este acuerdo de ACH permanecerá en vigor hasta que la compañía cancele o reciba notificación por escrito de su cancelación en un tiempo de 20 días para tomar acción. Dicha notificación escrita debe ser enviada a la siguiente dirección: **MAPFRE PUERTO RICO / PO BOX 70297 / SAN JUAN PR 00936-8297**

I authorize MAPFRE Puerto Rico(1) to begin the process of electronically debit my bank account or credit card. I have knowledge that the process of ACH transactions to my account or credit card transactions must comply with the provisions of Federal Law.

MAPFRE Puerto Rico reserves the right to refuse or cancel payment services electronically. This agreement shall remain in force until MAPFRE Puerto Rico cancel or receive written notice of your cancellation and have 20 days to take action. Such written notice must be sent to the following address: **MAPFRE PUERTO RICO / PO BOX 70297 / SAN JUAN PR 00936-8297**

Firma autorizada / Authorized signature: _____ Fecha / Date: _____

1 MAPFRE Puerto Rico denomina colectivamente a MAPFRE PRAICO Insurance Company, MAPFRE Pan American Insurance Company, MAPFRE Life Insurance Company of Puerto Rico / MAPFRE Puerto Rico collectively referred to MAPFRE PRAICO Insurance Company, MAPFRE Pan American Insurance Company, MAPFRE Life Insurance Companyof Puerto Rico

2 Al envío de mensajes de texto puede aplicar cargos adicionales de acuerdo al plan que el cliente tiene con su proveedor de telefonía celular y MAPFRE Puerto Rico no es responsable de esos cargos. / The delivery of text messages may apply additional charges according to the plan the customer has with their cellular provider and MAPFRE Puerto Rico is not responsible for those charges.

A quien pueda interesar:

Quiero por este medio reconocer a Medicalink, Corp. como la Agencia General de seguros para mi cubierta médico-hospitalaria, sin limitarse a gestiones en el futuro de negociar cubierta y/o beneficios que pudieran surgir con las compañías de seguros en mi beneficio.

Igualmente autorizo, en cumplimiento a la ley HIPAA, que se le entregue a Medicalink, Corp. cualquier información médica mía que pueda ésta necesitar, a raíz de una investigación solicitada por mí.

Sin otro particular quedo

Atentamente,

_____ _____

Nombre Asegurado **Fecha**

_____ _____

Firma Asegurado **Plan Médico**

_____ _____

Número de Seguro Social **Cubierta**

_____

Correo Electrónico