

MCS LIFE INSURANCE COMPANY



SUBSCRIPTION / CHANGE GROUP FORM

PLEASE PRINT AND USE BLACK INK TO COMPLETE THIS FORM. THE INSCRIPTION SHOULD BE COMPLETED ENTIRELY IN ORDER TO BE PROCESSED, INCLUDING THE SPACE FOR SOCIAL SECURITY NUMBER.

ACTION TO CARRY OUT: <input type="checkbox"/> I will not be participating in the company's health care plan <input checked="" type="checkbox"/> New Enrollment <input type="checkbox"/> Late Subscription <input type="checkbox"/> Change <input type="checkbox"/> Reinstatement <input type="checkbox"/> Renewal <input type="checkbox"/> Termination							
COMPLETE ACCORDING TO THE SELECTION OF YOUR EMPLOYER:							
Product Name:		Metal Name:		Preferred MCS Care Club* :			
Type of Benefit (PYMES Groups 2-50):		Type of Benefit (Groups 51+):					
<input type="checkbox"/> Global Essential: Medical, Pharmacy, Dental 100, Vision <input type="checkbox"/> Global Premium: Medical, Pharmacy, Dental 100, Vision <input type="checkbox"/> Global Elite: Medical, Pharmacy, Dental 200, Vision		<input type="checkbox"/> MCS Global (includes life insurance) _____ <input type="checkbox"/> MCS Ideal <input type="checkbox"/> MCS Association - Individual <input type="checkbox"/> MCS Association - Group <div style="text-align: right;"> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision </div>					
Optional Coverages: <input type="checkbox"/> Dental 300 (only dental option for Global Essential) <input type="checkbox"/> Dental 400 <input type="checkbox"/> Life Insurance <input type="checkbox"/> Medicinal Cannabis				For MCS official use: Assigned benefit package number _____			
Select if you prefer another language, other than spanish: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ / Select if you want format: Braille <input type="checkbox"/> Yes Electronic <input type="checkbox"/> Yes							
MAIN INSURED INFORMATION							
Social Security or Contract Num. (Required)		Employee or Insured's Last Name		Employee or Insured's Name		M.I.	Gender
584-35-9626		Colon Maldonado		Aracelis			<input checked="" type="checkbox"/> F <input type="checkbox"/> M
Employee Postal Address: Street Address, PO Box, City, State, Zip Code		Home Phone		Work Phone		Mobile Phone	
64 Rio Grande St, Montecasino Heights, Toa Alta, PR 00953		(787) 9238171				Date of Birth 03/23/1972 Month ____ / Day ____ / Year ____	
E-mail		Medicare Number (MBI) -Required if eligible to Medicare		Employer's Name		Employment Date	
				GOODWILL DE PUERTO RICO, INC		12/14/2025 Month ____ / Day ____ / Year ____	
<input type="checkbox"/> Retired Month ____ / Day ____ / Year ____ <input type="checkbox"/> Handicapped Month ____ / Day ____ / Year ____ <input type="checkbox"/> COBRA Month ____ / Day ____ / Year ____		Tobacco use* * <input type="checkbox"/> Yes <input type="checkbox"/> No		Coverage Selection: <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Family <input type="checkbox"/> Couple		Effective Date 2/1/2026 Month ____ / Day ____ / Year ____	
Type of Change:		Are you covered under other health plan?		Name of Insurer which provides the other Plan		Policy Number	
		<input type="checkbox"/> Yes <input type="checkbox"/> No				Effective Date of Other Plan Month ____ / Day ____ / Year ____	
						Type of Benefit of Other Plan <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
* It is a voluntary wellness program in which the insured receives preventive services according to his/her age, gender and condition at no charge. Indicating the MCS "Care Club" of your preference does not limit free choice of any other Center of the contracted network.							
AUTHORIZATION FOR SENDING MATERIALS BY EMAIL AND RECEIPT OF TEXT MESSAGES							
By providing on this subscription form your email address or mobile number and/or that of your dependents (over 21 years of age) , you expressly authorize MCS Life or its subsidiaries, by itself or through a third party, for voluntary 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(es) or phone(s) provided, including via text message (SMS or MMS). Through this consent, you acknowledge that MCS Life and its subsidiaries does not charge for this service. However, certain charges for the receiving and sending of emails and/or text messages may apply according to the contract with your telephone service provider or mobile data. For more information on the applicable charges, you should contact your service provider. This consent shall be understood as 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 to consent for electronic delivery. To receive information electronically, it is necessary to have access to the technological equipment where you can access an email with the basic programs. When necessary, MCS Life will notify you of any change in the specifications of the equipment or application that is necessary to access, retain the documents or electronic information. You should contact our Customer Service Call Center for any of the following circumstances: you do not wish to receive or continue receiving communications via email and/or text message, request to receive a printed copy of the policy, notices and documents free of charge via postal 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 may receive other documents, including 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 www.mcs.com.pr. Only the primary insured can access the EOB of the dependents under 21 years old.							

INFORMATION OF ELEGIBLE DEPENDENTS THAT YOU WISH TO INCLUDE UNDER YOUR PLAN

Include: Legal spouse, children until they reach the age of twenty-six (26), natural children, foster children, adopted children, children by adjudication of custody of a court and stepchildren, minors whose custody, parental authority or guardianship has been granted or adjudicated to grandparents or other relatives who are primary insurers of this policy, any child over twenty-six (26) years of age who suffers from physical or mental disability and who does not have Medicare benefits (Part A, B or both). In addition, you can include consensual partners and / or same-sex consensual partners if authorized by the employer.

Participant Code	Last Name / Name / Middle Initial	Tobacco use**	Sex F / M	Date of Birth Month/Day/Year	Age	Relationship Description	Social Security Number (Required) or Contract Number	Is your dependent insured by another plan?	Name of Insurer which provides the other plan	Effective date of the other plan Month/Day/Year	Policy Number	Type of Coverage of the other plan	Type of Benefit of the other plan	Handicapped (Yes / No)
	Villafañe Colon, Adrian	<input type="checkbox"/> Yes <input type="checkbox"/> No	M	02/16/2007	18	Child	599-82-6973	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
	Villafañe Colon, David	<input type="checkbox"/> Yes <input type="checkbox"/> No	M	01/14/2004	21	Child	597-78-4485	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
	Villafañe Rosario, Pedro	<input type="checkbox"/> Yes <input type="checkbox"/> No	M	04/04/1971	54	Spouse	581-53-3831	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
		<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
		<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
		<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														
		<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Individual <input type="checkbox"/> Couple <input type="checkbox"/> Family	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision	
E-mail***														
Mobile Phone***														

** Tobacco use - means use of tobacco an average of four (4) or more times per week within a period of no more than six months. Includes tobacco products, with the exception of tobacco use for religious or ceremonial purposes. Also, tobacco use is defined based on the last time the tobacco product was used. ***Please complete if you are over twenty one (21) years old.

PATIENT'S RIGHTS AND RESPONSIBILITIES ACT NOTICE AND WRITTEN RESPONSIBILITY WAIVER

I, _____ with identification number _____, will comply with the obligations established in Article 16 of Public Law No. 194 of August 25 of 2000, which reads as follows:

Every insured person is required to familiarized themselves with the "Patient's Rights and Responsibilities Act" or an adequate and reasonable summary of said Act, as prepared or 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 Office of the Patient's Advocate at 787-977-0909 or with the Office of the Commissioner of Insurance at 787-304-8686 for help at any time. 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 Public Law No. 194 of August 25, 2000.

I received an adequate and reasonable summary of the Patient's Rights and Responsibilities Act.

Authorized Representative Name: _____

Authorized Representative Signature: _____

Authorized Representative Code: _____

Primary Insured Signature _____

Primary Insured Name: _____

Date: _____

Rights of the Insured

- To receive high quality health services
- To be treated with respect and recognize 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 and/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
- To choose the medical group, primary care physician, specialist, laboratory, pharmacy and x-rays of your preference, that are included in the health care
- To change the medical group 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.
- 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 case of termination or cancellation of coverage for a patient who is hospitalized at the time of the termination date of the plan, and the discharge date has been scheduled 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 request 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 Office of the Health Prosecutor at 787-977-0909 or with the Commissioner of Insurance Office at 787-304-8686 for help at any time.
- 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 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 established by your health plan.
- To read your contract or booklet of benefits coverage.

RESPONSIBILITIES OF THE INSURED

- To provide your physician with health information as complete and exact as possible, about your current health condition, prior illnesses, medicines, 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
- To keep yourself in a good state of health by calling and visiting your primary care physician.

ESTADO LIBRE ASOCIADO DE PUERTO RICO
(COMMONWEALTH OF PUERTO RICO)

DEPARTAMENTO DE SALUD
(DEPARTMENT OF HEALTH)
REGISTRO DEMOGRAFICO
(DEMOGRAPHIC REGISTRY)
CERTIFICACION DE MATRIMONIO
(CERTIFICATION OF MARRIAGE)

NUMERO
A397301

NUMERO DE CERTIFICADO (CERTIFICATE NUMBER)
152-1997-01439-024578-044096

NOMBRE DEL CONTRAYENTE (GROOM'S NAME)

PEDRO VILLAFANE ROSARIO

FECHA NACIMIENTO (BIRTHDATE)

04 ABR 1971

EDAD (AGE)

26

LUGAR NACIMIENTO (BIRTHPLACE)

SAN JUAN, PUERTO RICO

NOMBRE DEL PADRE (FATHER'S NAME)

PEDRO VILLAFANE

NOMBRE DE LA MADRE (MOTHER'S NAME)

CARMEN ROSARIO

NOMBRE DE LA CONTRAYENTE (BRIDE'S NAME)

ARACELIS COLON MALDONADO

FECHA NACIMIENTO (BIRTHDATE)

23 MAR 1972

EDAD (AGE)

25

LUGAR NACIMIENTO (BIRTHPLACE)

SAN JUAN, PUERTO RICO

NOMBRE DEL PADRE (FATHER'S NAME)

MONSERRATE COLON

NOMBRE DE LA MADRE (MOTHER'S NAME)

MYRIAM ELBA MALDONADO

LUGAR DE CELEBRACION (CELEBRATION PLACE)

BAYAMON, PUERTO RICO

FECHAS (DATES): CELEBRACION (CELEBRATION)

18 OCT 1997

INSCRIPCION (REGISTRATION)

23 OCT 1997

CELEBRANTE (OFFICIANT)

SACERDOTE (PRIEST)

NOMBRE DEL CELEBRANTE (OFFICIANT NAME)

PEDRO GORENA

FECHA EXPEDICION (DATE ISSUED)

28 ABR 1999

ESTE ES UN ABSTRACTO DEL CERTIFICADO DE
MATRIMONIO OFICIALMENTE INSCRITO EN EL
REGISTRO DEMOGRAFICO DE PUERTO RICO BAJO
LA AUTORIDAD CONFERIDA POR LA LEY 24 DEL
22 DE ABRIL DE 1931

THIS IS AN ABSTRACT OF THE RECORDS FILED
IN THE DEMOGRAPHIC REGISTRY OF PUERTO
RICO ISSUED UNDER THE AUTHORITY OF
LAW 24, APRIL 22, 1931

SECRETARIO DE SALUD
(SECRETARY OF HEALTH)

DIRECTOR REGISTRO DEMOGRAFICO
(STATE REGISTRAR)



Dando Salud... a tu Vida.

ADVERTENCIA: Cualquier alteración o borradura cancela esta certificación.

WARNING: Any alteration or erasure voids this certification.

GOBIERNO DE PUERTO RICO
GOVERNMENT OF PUERTO RICO

DEPARTAMENTO DE SALUD - REGISTRO DEMOGRAFICO
(DEPARTMENT OF HEALTH - DEMOGRAPHIC REGISTRY)

CERTIFICACION DE NACIMIENTO
(CERTIFICATION OF BIRTH)

NUMERO
D8667388

NUMERO DE CERTIFICADO (CERTIFICATE NUMBER)
152-2007-00687-005243-044262-05937042

NOMBRE DEL INSCRITO (NAME OF REGISTRANT)
ADRIAN VILLAFANE COLON

FECHA NACIMIENTO (BIRTHDATE)
16 FEB 2007

FECHA INSCRIPCION (REGISTRATION DATE)
20 FEB 2007

LUGAR NACIMIENTO (BIRTHPLACE)
BAYAMON, PUERTO RICO

SEXO (SEX)
M

NOMBRE DEL PADRE (FATHER'S NAME)
PEDRO VILLAFANE ROSARIO

LUGAR NACIMIENTO DEL PADRE (FATHER'S BIRTHPLACE)
SAN JUAN, PUERTO RICO

NOMBRE DE LA MADRE (MOTHER'S NAME)
ARACELIS COLON MALDONADO

LUGAR NACIMIENTO DE LA MADRE (MOTHER'S BIRTHPLACE)
SAN JUAN, PUERTO RICO

FECHA EXPEDICION (DATE ISSUED)
24 MAY 2018

ESTE ES UN ABSTRACTO DEL CERTIFICADO DE
NACIMIENTO OFICIALMENTE INSCRITO EN EL
REGISTRO DEMOGRAFICO DE PUERTO RICO
BAJO LA AUTORIDAD CONFERIDA POR LA LEY 24
DEL 22 DE ABRIL DE 1931

THIS IS AN ABSTRACT OF THE BIRTH CERTIFICATE
FILED WITH THE DEMOGRAPHIC REGISTRY OF
PUERTO RICO ISSUED UNDER THE AUTHORITY OF
LAW 24, APRIL 22, 1931

Departamento de Salud
Registro Demografico

Pago/Paid

Coleccion Virtual

Transaccion # 28704329


SECRETARIO DE SALUD
(SECRETARY OF HEALTH)


DIRECTOR REGISTRO DEMOGRAFICO
(STATE REGISTRAR)



ADVERTENCIA/WARNING: No es valido sin la presencia de la Marca de Agua
Not valid without seen Watermark
Cualquier alteracion o borradura cancela esta Certificacion
Void if altered or Erased

NO ES VALIDO SI SE ALTERA
VOID IF ALTERED



GOBIERNO DE PUERTO RICO
GOVERNMENT OF PUERTO RICO

DEPARTAMENTO DE SALUD - REGISTRO DEMOGRAFICO
(DEPARTMENT OF HEALTH - DEMOGRAPHIC REGISTRY)

CERTIFICACION DE NACIMIENTO
(CERTIFICATION OF BIRTH)

NUMERO
08667387

NUMERO DE CERTIFICADO (CERTIFICATE NUMBER)
152-2004-00327-001598-044262-05660002

NOMBRE DEL INSCRITO (NAME OF REGISTRANT)
DAVID ALEJANDRO VILLAFANE COLON

FECHA NACIMIENTO (BIRTHDATE)
14 ENE 2004

FECHA INSCRIPCION (REGISTRATION DATE)
22 ENE 2004

LUGAR NACIMIENTO (BIRTHPLACE)
BAYAMON, PUERTO RICO

SEXO (SEX)
M

NOMBRE DEL PADRE (FATHER'S NAME)
PEDRO VILLAFANE

LUGAR NACIMIENTO DEL PADRE (FATHER'S BIRTHPLACE)
RIO PIEDRAS, PUERTO RICO

NOMBRE DE LA MADRE (MOTHER'S NAME)
ARACELIS COLON

LUGAR NACIMIENTO DE LA MADRE (MOTHER'S BIRTHPLACE)
SAN JUAN, PUERTO RICO

FECHA EXPEDICION (DATE ISSUED)
24 MAY 2018

ESTE ES UN ABSTRACTO DEL CERTIFICADO DE
NACIMIENTO OFICIALMENTE INSCRITO EN EL
REGISTRO DEMOGRAFICO DE PUERTO RICO
BAJO LA AUTORIDAD CONFERIDA POR LA LEY 24
DEL 22 DE ABRIL DE 1981

THIS IS AN ABSTRACT OF THE BIRTH CERTIFICATE
FILED WITH THE DEMOGRAPHIC REGISTRY OF
PUERTO RICO ISSUED UNDER THE AUTHORITY OF
LAW 24, APRIL 22, 1981

Departamento de Salud
Registro Demografico

Pago/Paid

Coleccion Virtual

Transaccion: 0892 4276

SECRETARIO DE SALUD
(SECRETARY OF HEALTH)

DIRECTOR REGISTRO DEMOGRAFICO
(STATE REGISTRAR)

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