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

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

T 787.250.5214 **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 (m/d/y):**	
Occupation:		**Date Employed (m/d/y):**		**Annual Salary:**	
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)

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	

Section F: COBRA

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

Rev. 04/04