Annual Enrollment 2024-2025

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: ☐ **I will not be participating in the company's health care plan** ☐ **New Enrollment** ☐ **Late Subscription** ☐ **Change** ☐ **Reinstatement** ☐ **Renewal** ☐ **Termination**

COMPLETE ACCORDING TO THE SELECTION OF YOUR EMPLOYER:

Product Name:	**Metal Name:**
SPARC PR LLC - MCS Global Standard - 791815	SPARC PR LLC - MCS Global Standard - 791815

Type of Benefit (PYMES Groups 2-50):

- ☐ **Global Essential:** Medical, Pharmacy, Dental 100, Vision
- ☐ **Global Premium:** Medical, Pharmacy, Dental 100, Vision
- ☐ **Global Elite:** Medical, Pharmacy, Dental 200, Vision

Type of Benefit (Groups 51+):

☒ **MCS Global** (includes life insurance) _____ ☐ **MCS Ideal** ☐ **MCS Association** - Individual ☐ **MCS Association** - Group

☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision

Optional Coverages: ☐ Dental 300 (only dental option for Global Essential) ☐ Dental 400 ☐ Life Insurance ☐ Medicinal Cannabis (only for grups 51+)

For MCS official use: Assigned benefit package number _____

Select if you prefer another language, other than spanish: ☐ English ☐ Other: _____ / Select if you want format: Braille ☐ Yes Electronic ☐ Yes

MAIN INSURED INFORMATION

Social Security or Contract Num. (Required)	Employee or Insured's Last Name	Employee or Insured's Name	M.I.	Gender	Group Number
				☐ F ☐ M	791815

Employee Postal Address: Street Address, PO Box, City, State, Zip Code	Home Phone	Work Phone	Mobile Phone	Date of Birth	Division Number
				Month ___ / Day ___ / Year ____	

E-mail	Medicare Number (MBI)--Required if eligible to Medicare	Employer's Name	Employment Date
		SPARC Group, LLC	Month ____/Day_____/Year_____

☐ Retired	Month____/Day____/Year_____	Tobacco use*	Coverage Selection:	Effective Date
☐ Handicapped	Month____/Day____/Year_____	☐ Yes ☐ No	☐ Individual ☐ Family ☐ Couple	Month 10 / Day 01 / Year 2024
☐ COBRA	Month____/Day____/Year_____			

Type of Change:	Are you covered under other health plan?	Name of Insurer which provides the other Plan	Policy Number	Effective Date of Other Plan	Type of Benefit of Other Plan
	☐ Yes ☐ No			Month ____/Day_____/Year_____	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision

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.

Original- White: MCS / 1st Copy - Yellow: MCS / 2nd Copy- Pink: Employer

Complete this section if you are adding or removing dependents

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)
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ Vision	
E-mail**														
Mobile Phone**														
		☐ Yes ☐ No						☐ Yes ☐ No				☐ Individual ☐ Couple ☐ Family	☐ Medical ☐ Dental ☐ Pharmacy ☐ 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.

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ADDITIONAL INFORMATION

If your spouse or partner and/or dependents have other health plan, indicate if he/she is an active or retired employee

Spouse or partner	☐ Active	☐ Retired
Dependent	☐ Active	☐ Retired
Dependent	☐ Active	☐ Retired
Dependent	☐ Active	☐ Retired
Dependent	☐ Active	☐ Retired

If your spouse or partner and/or dependents are retired, indicate retirement date

Retirement Date	Month ____ / Day ____ / Year _____
Retirement Date	Month ____ / Day ____ / Year _____
Retirement Date	Month ____ / Day ____ / Year _____
Retirement Date	Month ____ / Day ____ / Year _____
Retirement Date	Month ____ / Day ____ / Year _____

Do you and/or any of your dependents have End Stage Renal Disease (ESRD)?
(Note: This information will be used only to coordinate benefits with Medicare.)

☐ You	From:	Month _____ / Day _____ / Year _____
☐ Spouse or partner	From:	Month _____ / Day _____ / Year _____
☐ Dependent	From:	Month _____ / Day _____ / Year _____
☐ Dependent	From:	Month _____ / Day _____ / Year _____
☐ Dependent	From:	Month _____ / Day _____ / Year _____
☐ Dependent	From:	Month _____ / Day _____ / Year _____

Are you or any of your dependents covered by Medicare?

☐ You	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____
☐ Spouse or partner	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____
☐ Dependent	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____
☐ Dependent	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____
☐ Dependent	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____
☐ Dependent	Part A ____ / ___ / _____	Part B ____ / ____ / _____	Part D ____ / ____ / _____

Effective Date (Month / Day / Year):

Medicare Number (MBI)- Required if eligible to Medicare

You	_____
Spouse or partner	_____
Dependent	_____
Dependent	_____
Dependent	_____
Dependent	_____

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

If your employer chose a product which includes life insurance, write the name and benefit % corresponding to the persons you designate as beneficiaries for life insurance. Your employer receives and maintains a copy of this information provided for the designation of beneficiaries of your insurance, in case there is a claim. If your employer did not choose a product that includes life insurance, this benefit does not apply to your coverage. Life insurance will be available for the principal insured over 18 and under 65.

	Primary Beneficiaries	Relationship	Date of Birth Month / Day / Year	Benefit	Contingent Beneficiaries	Relationship	Date of Birth Month / Day / Year	Benefit

Notes: 1. An insured can name one (1) or more beneficiaries to receive the amount payable upon his/her death. The appointment or change of beneficiary should be done: in writing, signed by the insured and registered in MCS Life Insurance Company.

ADMINISTRATIVE INFORMATION

I certify that I read the information included in this form or that it was read to me, that the same is true and correct. I authorize any provider, hospital or other medical services facility, insurance company or other institution to provide the information MCS requires.

Employee signature	Date	Employer signature	Date

PROVISIONS OF THE HEALTH PLAN

1. I authorize the payment of any and all benefits payable under the policy at any licensed health care provider who treats me and/or my dependents.

2. **USES AND DISCLOSURE AUTHORIZED BY LAW OF THE PROTECTED HEALTH INFORMATION:** MCS Life Insurance Company has the obligation and commitment of keeping the privacy and confidentiality of your protected health information (PHI) according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). MCS Life Insurance Company as Plan administrator can disclose PHI without the insured's authorization to fulfill functions related to your treatment, payment of medical services and health care operations. For more details regarding HIPAA and Privacy Practices access to mcs.com.pr, select HIPAA, Notices of Privacy Practices.

3. **FRAUD NOTICE:** In accordance with the dispositions of Act 230 of August 9th, 2008, provides the following: "Any person who knowingly and with the intention to defraud present false information in an insurance request or, presents, or help or make a fraudulent complaint for the payment of a loss or benefit, or presents more than one claim for the same damage or loss, will commit a serious crime and if convicted, will be sanctioned for each violation with a fine no less than five thousand ($5,000) dollars, nor greater of ten thousand ($10,000) dollars or imprisonment by a fixed term of three (3) years, or both. If aggravating circumstances exist, the term of imprisonment could be increased up to a maximum of five (5) years; if mitigating circumstances mediate, it could be reduced a minimum of two (2) years.

4. I hereby certify that I was provided appropriate orientation regarding benefits under all the Health Care Plan alternatives offered by my employer.

CONFIDENTIALITY NOTICE

This form, once completed, includes privileged and confidential information and therefore, the information included is for the exclusive use of the person or entity addressed. If you receive it by mistake, you are not authorized to review, spread, distribute or photocopy it. If you received this information by mistake please notify immediately at 787.758.2500 to make arrangements for return or destruction of documents.

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 provider
• 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
• 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.

RESPONSIBILITES 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.
• To follow the medical treatment agreed by your physician.
• To inform your health professional if you anticipate problems in the prescribed treatment.
• The patients are responsible for recognizing the impact that their lifestyle is having on their personal health and to assume the initial personal responsibility for their own health and care.
• To participate in all decisions related to your health care.
• To provide the necessary information about health plans and to collaborate with the provider regarding your respective financial arrangements when it is necessary to pay in a timely manner all accounts and bills sent to you.
• To inform if you have another health plan.
• To inform the authorities about any improper action or fraud that you have knowledge of in regard to the physician-hospital health facilities and services.
• Responsibility to comply with the operational and administrative procedures of your health plan, health services provider, and the government health benefit
• To be informed of the type of coverage, options, benefits, limits, exclusions, referrals and grievance filing, review and solution procedures of your health plan.
• To pay the assigned deductible, as indicated on your card.
• To respect that the services of this plan are for the person enrolled. The unlawful use of the MCS Life Insurance Company Health Card is prohibited by law.
• To respect the enjoyment of other people at the service offered in health facilities.
• The patients, their family members and companions are responsible for making the corresponding arrangements so that the needs of the hospital, of other patients, of the medical faculty, and other employees are not affected by your particular actions.
• To recognize the risks and limits of medicine and the possibility of mistakes by the healthcare professionals.
• To not engage in behavior or disturb the peace in the health facilities.