ARS UNIVERSAL

Affiliation Request Form

General information

INCLUSION	PRODUCT	CONTRACT NUMBER AND FAMILY
☐ Main title holder ☐ Dependant		

Applicant information

NAME		SURNAME	
ID NUMBER	DATE OF BIRTH (dd/mm/aaaa)	NACIONALITY	GENDER ☐ F ☐ M

MARITAL STATUS

☐ Single ☐ Married ☐ Free union

HOME ADDRESS (Street and number)

NEIGHBORHOOD	CITY	APARTMENT NAME	APARTAMENT/HOUSE NUMBER
CELULAR	PHONE	EMAIL	

Business or work information

BUSINESS NAME	TAXPAYER ID

ADDRESS

NEIGHBORHOOD	CITY	APARTMENT
PHONE	EMAIL	

Health promoter information

NAME AND SURNAME	ID OR TAXPAYER NUMBER

Promoter signature

ARS's Stamp

I, the main title holder, freely and voluntarily declare my decision to join the ARS Universal; therefore, I authorize the ARS of my choice to review, if necessary, my clinical file, both in outpatient and hospitalization, in order to comply with the payment of health care providers coverages of the Basic Health Plan of the health insurance of the Dominican social security system.

ID NUMBER

Affiliate's complete name

Affiliate's signature

Left Right

Fingerprints

Health declaration

To the best of my knowledge and belief the applicants for this insurance have been diagnosed or treated for:

	Yes	No
1. Deformity, amputation or physical disability.	☐	☐
2. Within the last five years, have been hospitalizaed for illness, accident or surgery.	☐	☐
3. Benign or malignant tumors or cancer.	☐	☐
4. Kidney or bladder, disordeas o alterations.	☐	☐
5. Goiter, thyroid alterations or diabetes.	☐	☐
6. Epilepsy, gout, mental or nervous disorders.	☐	☐
7. Have you been treated for alcohol or drug abuse.	☐	☐
8. Gallbladder,stomach, liver, bowels, pancreas, hernia, ulcer,hemorrhoid alteration.	☐	☐
9. Disorders of the eyes, glaucoma, cornea.	☐	☐
10. Coronary heart disease, cardiovascular disorder or any alteration in blood pressure.	☐	☐
11. Tuberculosis, asthma, bronchitis or any other respiratory disorder.	☐	☐
12. Arthritis, rheumatism, rheumatoid arthritis or disorders of the muscle, spine, back, bones or joints	☐	☐
13. For women only: disorders of the ovaries, uterus, breast, lumps, abnormal discharge or any other gynecological or breast disorder.	☐	☐
14. For men only: have had any alterations in the prostate? Have had a PSA test?	☐	☐
15. AIDS/HIV	☐	☐
16. Are you pregnant? If so indicate how many weeks (or months) _____	☐	☐
17. Other _____		

If you answered "Yes" to any of the questions mentioned above, please the following information

Quest. Number	Proposed insured	Diagnosis & treatment	Date of diagnosis or procedure	Name and address/phone/emails of doctors or hospitals

Contract details

PAYMENT ☐ Monthly ☐ Quarterly ☐ Semianual ☐ Yearly

INVOICE ☐ Physical ☐ Electronic

ADDITIONAL BENEFITS ☐ Catastrophic ☐ Ambulance ☐ Vision ☐ Last expenses ☐ Dental*

AEROAMBULANCIA ☐ Alert Plus_____ ☐ Movi Alert_____

AMBULATORY MEDICINE AMOUNT %

RATE

SEVERANCE

DENTAL

LAST EXPENSES

COMMENTS AND/OR SPECIAL CONDITIONS

1 _____

2 _____

3 _____

*Applies only to Exclusive Plan members.

Note: If there are NO observations, place N/A (Not Applicable)

UNIVERSAL (hereinafter "The Company") reserves the right to refuse or accept any registration request. Coverage will become effective on the approval date of this request as indicated by The Company. You agree that all the previously mentioned answers are complete and truthful according to your knowledge and understanding. If this request contains any false answers, the contract may be cancelled by the Company without any legal consequence against same.

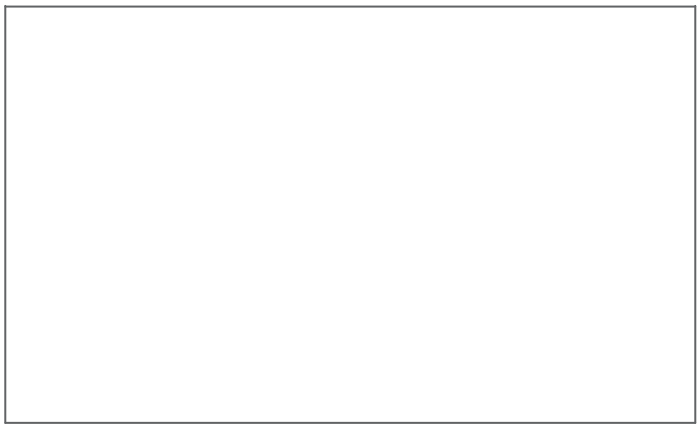
I authorize any doctor, professional, hospital, clinic, government agency or any other medical person or medically related person, to provide the Company with any information that may include registration copies concerning the care or treatment given to me and/or my dependants without limiting any information related to mental illnesses or the use of drugs or alcohol.

The person making the request expressly and irrevocably authorizes the Company to supply credit information centers with the patrimonial and extra-patrimonial information necessary for other subscribing institutions of said information centers to perform credit evaluations. Said person recognizes and guarantees that the revelation of said information on the part of The Company and/or their respective employees, executives, and shareholders, will not result in any violation of professional secrecy in relation to Article 377 of the Dominican Penal Code, and will not generate any responsibility under Articles 1382 and those to follow of the Dominican Civil Code, or under any other legal text, and at the same time expressly and formally resigns to the exercise of any legal action or demand claiming against damages and losses due to said cause, or due to the supply of inexact information, and promise that representatives, shareholders, and other assignees thereof will abide to the stipulations of this article by virtue of the provisions of Article 1120 of the Dominican Civil Code.

Branch _____ Code _____ Promoter _____ Code _____ Supervisor _____ Code _____

Signature and company seal _____ Title holder signature _____ Date _____

Copy of identification ID



Front copy of identification ID

Back copy of identification ID

Note: The employee's copy of the identification id must be completely legible.