

**Affiliation Request Form**
**General information**

INCLUSION <input type="checkbox"/> Main title holder <input type="checkbox"/> Dependant	PRODUCT	CONTRACT NUMBER AND FAMILY
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**Applicant information**

NAME		SURNAME	
ID NUMBER	DATE OF BIRTH (dd/mm/aaaa)	NACIONALITY	GENDER <input type="checkbox"/> F <input type="checkbox"/> M

MARITAL STATUS  
 Single  Married  Free union

HOME ADDRESS (Street and number)

NEIGHBORHOOD	CITY	APARTMENT NAME	APARTAMENT/HOUSE NUMBER
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CELULAR	PHONE	EMAIL
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**Business or work information**

BUSINESS NAME	TAXPAYER ID
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ADDRESS

NEIGHBORHOOD	CITY	APARTMENT
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PHONE	EMAIL
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**Health promoter information**

NAME AND SURNAME	ID OR TAXPAYER NUMBER
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\_\_\_\_\_  
Promoter signature



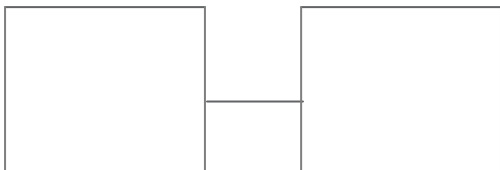
ARS's Stamp

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

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 <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semianual <input type="checkbox"/> Yearly		INVOICE <input type="checkbox"/> Physical <input type="checkbox"/> Electronic	
ADDITIONAL BENEFITS <input type="checkbox"/> CatastrophieW <input type="checkbox"/> Ambulance <input type="checkbox"/> Vision <input type="checkbox"/> Last expenses <input type="checkbox"/> Dental*			
AEROAMBULANCIA <input type="checkbox"/> Alert Plus _____ <input type="checkbox"/> Movi Alert _____		AMBULATORY MEDICINE AMOUNT _____ %	
SEVERANCE		DENTAL	LAST EXPENSES

COMMENTS AND/OR SPECIAL CONDITIONS

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

\*Applies only to Exclusive Plan members.

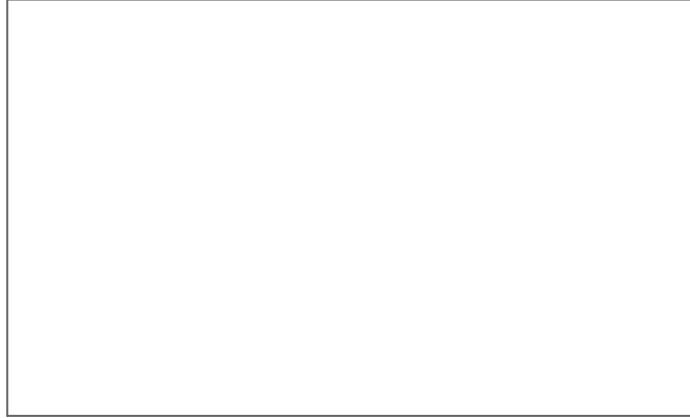
Note: If there are NO observations, place N/A (Not Applicable)

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	



Front copy of identification ID



Back copy of identification ID

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