TRIPLE-S VIDA

Triple-S Vida, Inc.

TRIPLE-S VIDA, INC. agrees to pay benefits for losses resulting exclusively from first cancer diagnosis according to the terms, conditions, exclusions and limitations of this policy.

This policy is issued in consideration of the application and payment of the premium.

IMPORTANT INFORMATION FOR YOU

This policy is issued based upon the statements you made on the application, a copy of which is attached to the Policy. If your answers to questions that are relevant for accepting the risk assumed by Us are incorrect or untrue, We may deny benefits or cancel the Policy, within the first two (2) years from the issuance of the policy subject to Time Limits on Certain Defenses. Examine your policy carefully. The time to clear up any question is now, before a claim arises. If you find that any of your statements on the application is incorrect or contrary to the facts, please contact our Main Office's Insured Service Department at (787) 758-4888.

NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY

If you are not satisfied with this policy, you may cancel it no later than 10 days from receipt by sending it back to our Main Office or to the insurance agent through whom you acquired the Policy. Immediately after returning it or mailing it back, this policy will be regarded as never having been issued. Any premiums paid will be returned within 10 days after We receive the Policy.

This policy is a legal contract between You and **TRIPLE-S- VIDA, INC.**

Signed by **TRIPLE-S VIDA, INC.** on the Policy's Effective Date.

Senior Vicepresident of Finance

CANCER POLICY
LIMITED BENEFITS
FIRST CANCER DIAGNOSIS BENEFIT
GUARANTEED RENEWAL

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
IF YOU OR ANY PERSON PROPOSED FOR INSURANCE UNDER THIS POLICY IS ELIGIBLE FOR MEDICARE BENEFITS, PLEASE CONSULT THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, AVAILABLE AT OUR COMPANY

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DEFINITIONS

In this policy:

Additional Insured is the person who is a dependent of the Primary Insured, related to him/her by kinship, affinity or affection and named as such in the application.

Cancer: A malignant tumor characterized by the abnormal and uncontrolled growth with the ability of invading and destructing tissue. Cancer includes Leukemia, Kaposi's Sarcoma and Hodgkin's Disease. A positive cancer diagnosis has to be issued by a physician who is an Oncology Hematologist or Pathologist.

Benefit is the amount of money, which it is shown on the Policy Specification, We agreed to pay for the first cancer diagnosis.

Dependent Child means the Primary Insured's son or daughter, stepchild, legally adopted child or foster child who depends on the Primary Insured for his or her support and at the time of the application for this policy has not reached 21 years of age, or 25 years of age if he or she is a full-time student at an accredited public school, private school or university.

A child born to the Primary Insured while this policy is in force will himself or herself become an Insured on the date of his or her birth. A child adopted by the Primary Insured while this policy is in force will become an Insured on the date of the final decree of adoption, if received within 30 days of birth or adoption, as the case may be:

a) The minor's enrollment application; and
b) Information that will allow us to identify the new Insured; and
c) The corresponding premium payment

First Cancer Diagnosis means that, for the first time, one of the following takes place:

1. A pathologist provides a positive cancer diagnosis for the first time in the Insured's lifetime. The pathological diagnosis must be based on the microscopic examination of fixed tissue or preparations of the hemic system (either while living or postmortem). The Physician providing the pathological diagnosis shall base his/her judgment solely on the criteria of malignancy as accepted by the American Pathology Board or the Osteopathic Pathology Board after studying the histocytological architecture or pattern of the suspected tumor, tissue or specimen. A pathological postmortem Cancer diagnosis shall only be accepted as a First Diagnosis if the deceased Insured received treatment for such Cancer prior to his/her death.

2. Cancer is positively diagnosed for the first time in the Insured's life, by means of clinical or non-pathological diagnosis, if a tissue diagnosis cannot be performed. A clinical or non-pathological Cancer diagnosis shall only be accepted as a First Diagnosis if it is not medically feasible to attempt a pathological diagnosis. Proof that it is not medically feasible to attempt a pathological diagnosis must be deemed satisfactory by Us. These satisfactory tests will be such as chest X-rays, computerized radiographies, computerized tomography, magnetic resonance image, positron emission tomography, duly accompanied by an oncologist doctor's clinical diagnosis or any other evidence generally accepted in the medical community. We reserve the right to request additional information, an additional statement by the Physician, and/or an examination by a Physician selected by Us and paid by Us.

Foster Child is the child who, without being a natural or adoptive child, has lived from infancy under the same roof in a normal parent-child relationship with the Primary Insured.

Insured according to the Plan based on which the Policy is issued:

If the Plan is:	**Insured** includes:
Individual	Primary Insured only
Single Father/Single Mother	Primary Insured and his/her Dependent Children
Married Couple	Primary Insured and his/her Spouse
Couple	Primary Insured and Additional Insured
Family	Primary Insured, his/her Spouse and their Dependent Children

Mailing address is PO Box 363786, San Juan, PR 00936-3786.

Main Office is located on 1052 Ave Muñoz Rivera, San Juan, PR 00927-5018

Physician - A legally licensed physician who, acting within the scope of his/her license, is authorized to provide services covered by this policy. The term physician does not include You, any Insured or a member of Your immediate family.

Preexisting Condition means a condition for which diagnosis, advice, recommendation or treatment was obtained or for which signs or symptoms existed which would have caused and ordinarily prudent person to seek diagnostic, advice, recommendation or treatment, prior to the Effective Date of this policy.

Primary Insured is the person designated as such in the application and in the Policy Specification.

Benefit is the amount of money, which it is shown on the Policy Specification, We agreed to pay for the first cancer diagnosis.

Policy refers to this policy.

Policy's Effective Date is the date when the insurance under the policy begins. The Policy's Effective Date appears on the Policy Specification. Nevertheless, no insurance under the Policy will begin until the Policy is delivered, and the initial premium is received at our Main Office. The Policy's Effective Date is also the date after which years and months are measured in the Policy. A Policy year is a period of twelve consecutive months. A Policy month is the period that begins on the same day of the month as the Policy's Effective Date and ends one day before the same day on the following month.

If the initial premium is paid through payroll deduction, the insurance will begin on the day of the deduction, provided our Main Office receives the premium. We may change the Policy's Effective Date, so it matches the day We received the first premium. If We change the Policy's Effective Date, We will send you a new Policy Specification bearing the new Effective Date.

Postmortem Diagnosis if the Insured dies as a direct consequence of, but before a positive diagnosis of cancer, and if a post-mortem positive diagnostic of cancer is obtained, We will assume responsibility, retroactively.

Spouse is the legal spouse of the Primary Insured or the person he/she lives within an acknowledged husband-and-wife relationship and is named as such in the application.

Stepson/Stepdaughter is the child of the spouse of the Primary Insured in a previous marriage.

Waiting period means the period of 90 days following the policy effective date or following the reinstatement effective date of this policy during which the policy does not provide first cancer diagnosis coverage or benefit.

We, us or **our** refer to Triple-S Vida, Inc.

You or your or **yours** refer to the Policyholder.

PREMIUM

Premiums

After the first premium, all other premiums are payable on or before their due date at our Main Office. Premiums are due on the same day of the Policy's Effective Date, at the beginning of each period defined by the payment schedule. The premium and the payment schedule appear on the Policy Specification. Paying a premium will not keep the Policy in force after the next premium's due date, except as stated under the Grace Period.

Grace Period

A grace period of 31 days is granted to pay each premium due after the first premium, during this grace period the Policy will continue in force.

Reinstatement

If the policy lapses because a premium is not paid within the time period granted to issue a payment, later acceptance of the premium by Us or by one of our authorized representatives, without requiring an application for reinstatement, will reinstate the policy. Nevertheless, if We or our authorized representatives require a reinstatement application and a receipt is issued for the premium paid, the Policy will be reinstated on the date We approve your application, or 45 days after the date of receipt, unless We have previously written You of Our disapproval. The reinstated policy will cover only losses due to Cancer covered by the Policy that begin more than 10 days after such date. In any other respect, You and We will have the same rights with respect to the Policy as we had immediately before it lapsed, subject to any provisions attached to or endorsed relating to the reinstatement. Any Premium accepted in connection with the reinstallation will apply to a period for which no premium has been previously paid, but not to any period greater than sixty days prior to the date of the reinstatement.

BENEFIT

We will pay the benefits specified herein for First Cancer Diagnosis provided that:

1. The cancer is diagnosed after 90 days from the policy effective or from the reinstatement date and while the policy is in force, and
2. The insured has not been diagnosed or received treatment, advice, or medical consultation related to cancer before the date of the application to this policy.

FIRST CANCER DIAGNOSIS BENEFIT

We will pay the total insurance amount of the policy in a lump sum payment upon receipt of satisfactory proof of loss of cancer diagnosed for the first time after 90 days from the policy effective date or from the reinstatement date. This benefit is payable only once during the lifetime of the insured. Skin cancer is excluded, except malignant melanoma cancer.

Satisfactory proof of loss means a certified pathological report or other loss of proof which established the positive diagnosis of cancer.

If the insured receives a first internal cancer diagnosis of internal Cancer or Malignant Melanoma, we will pay the first diagnosis of cancer benefit. The diagnosis must occur after the waiting period and while insured under this policy. We will not pay benefits for diagnosis of skin cancer other than Malignant Melanoma.
The payable first cancer diagnosis benefit is shown on the Policy Specification.

Post mortem first cancer diagnosis - if the insured dies as a direct result, but before a positive first cancer diagnosis and this positive diagnosis is obtained post mortem, we will assume liability retroactively.

LIMITATIONS AND EXCLUSIONS

This policy provides benefits only for losses resulting from cancer as these are defined in the policy. Benefits will not be paid for losses resulting from:

1. Any other disease or ailment, or
2. Any illness or disability caused, complicated, aggravated, or affected by cancer.
3. This policy provides benefits solely because a first diagnosis of internal Cancer or Malignant Melanoma. This policy does not cover any other disease, ailment, or disability, even though such other disease, ailment or disability could have been complicated, affected or caused, directly or indirectly, by cancer. Benefits will not be paid for diagnosis of skin cancer, Malignant Melanoma except.
4. The first cancer diagnosis benefit will not be paid when any consultation or treatment received within the waiting period, or prior to the policy effective date, leading to the first cancer diagnosis.
5. Preexisting conditions limitations - nothing contained in this policy will be construed to allow payment for first cancer diagnosis resulting from a pre-existing condition, regardless of when the diagnosis was made.

TERMINATION AND CONTINUATION OF INSURANCE

TERMINATION OF THE POLICY

This policy will end on the first occasion in which one of the following occurs:

a) The death of the primary insured, subject to Insurance Continuation provisions for the additional insured, spouse or dependent child.
b) The payment of the benefit to the primary insured, subject to Insurance Continuation provisions for the additional insured, spouse or dependent child.
c) When the primary insured turn 70 years old, subject to Insurance Continuation provisions for the additional insured, spouse or dependent child.
d) The grace period expires, and the overdue premium has not been paid.
e) When you request the termination in writing.
f) Regarding any insured;
    1. When his/her insurance under the Policy is terminated;
    2. Once First Cancer Diagnosis benefits are paid; or

3. He/she turns 70 years old.

TERMINATION OF AN INDIVIDUAL'S INSURANCE

Dependent Child
A Dependent Child's insurance will terminate when: (a) when the Policy is terminated, (b) when he/she no longer fulfills the definition of a Dependent Child, or (c) if it's a stepchild, when the Spouse's insurance terminates, whichever happens first.

Nevertheless, a dependent child's insurance will not terminate when he/she has reached 21 years of age, if upon reaching that age, he/she is incapable of sustaining himself/herself by his/her own means due to a physical handicap or mental retardation. The child's coverage will continue while the disability lasts, and the Policy is in force. We may request proof of such continued disability and dependency at reasonable intervals, but not more frequently than once a year. If the evidence is not provided within 60 days after the date of Our request, coverage for the dependent child will end.

Spouse
A Spouse's insurance will terminate when: (a) the Policy is terminated, (b) he/she no longer fulfills the definition of a Primary Insured's Spouse, or (c) You request it in writing, whichever happens first.

Additional Insured
An Additional Insured's insurance will terminate when: (a) the Policy is terminated, or (b) when he/she no longer fulfills the definition of Additional Insured, or (b) You request it in writing.

INSURANCE CONTINUATION

a) You must request in writing within 30 days from the end of the Primary Insured, Spouse, Additional or Dependent Child insurance coverage, as it may applied, the opportunity to continue receiving protection for the first cancer diagnosis under the applicable Plan according to the Definitions section and in return for the corresponding premium.

b) You must request in writing from the end of the Spouse or Additional Insured, Primary Insured insurance coverage, the modification of the plan under which You will continue receiving protection for the first cancer diagnosis in return for the corresponding premium.

If a Dependent Child's insurance ends for having reached the age limit, he/she may continue his/her insurance under a new individual policy if he/she requests it in writing within 30 days following the termination of his/her insurance under the Policy.

We will issue a new policy without requesting proof of insurability. Provisions regarding waiting periods and time limits for certain defenses in the new policy will take into consideration the time elapsed regarding such provisions in this policy. The new policy will be in the form that, on that date, it will be currently issued by Us. The premium will be according to the plan and rate in force for the age reached on the new policy's effective date.

GENERAL PROVISIONS

AGE LIMIT
Any coverage provided by the Policy for which identifiable premium is paid in relation to such coverage and for which there is termination for having reached a certain age and if the date when certain age is reached falls within a period for which We have accepted the premium or accept it after such date, will continue to be in force during the period for which the premium was accepted. In the event that the Insured's age was falsely stated, and if according to the Insured's correct age coverage provided by the Policy had not been in effect or had ended prior to accepting the premium or premiums, then Our responsibility shall be limited to returning all premiums paid during the period that was not covered by the Policy.

CHANGE OF BENEFICIARIES AND OTHER CHANGES
You alone have the right to change the beneficiary and no beneficiary's consent is needed to award or assign this policy or to make any changes in beneficiaries or make any other changes in this policy.

CIVIL ACTIONS

No civil action shall be brought to recover this policy within 60 days after written proof of the loss has been given as required by this Policy. No such action shall be brought after 3 years from the time written proof of loss is required to be given.

ENTIRE CONTRACT, CHANGES
The policy, application, endorsements and other attached documents, if any, constitute the entire insurance contract. No change in this policy will be valid until approved by one of Our executive officers and such approval is endorsed or attached to the Policy. No agent has the authority to change this policy or waive any of its provisions.

GUARANTEED RENEWAL
You have the right to renew this policy during your lifetime, for periods of 12 consecutive months, by paying the renewal premium starting on the due date of the policy's first anniversary. We have the right to change the premium at the beginning of each term. The renewal premium will apply to all new policies and those previously issued. We will not make changes for reasons of sex, physical condition of a covered person or for claims filed under this policy. No change will come into effect before a period of at least 30 days after mailing you a change notice to your last address on file with Us.

INCONTESTABILITY AFTER REINSTATEMENT
If this Policy is reinstated, it will only be contested due to fraud or misrepresentation of material facts in relation to the reinstatement and only for two years following the reinstatement date, unless the original 2-year period has not yet expired.

NOTICE
All matters related to this Policy that require notice must be made in writing and sent to our Main Office. We will issue a receipt for any claim notice within 15 days of receipt.

NOTICE AND PROOF OF LOSS

1. **Notice**
   a) We must receive, at our Main Office, claim notice, in writing, within 20 days after any loss covered by the Policy has occurred or begun, if possible. If it is not possible, We must receive the notice as soon as reasonably possible.

   b) After we received written notice of claim, we will furnish forms for filing Proofs of Loss. If such forms are not furnished within fifteen (15), the claimant will be deemed to have complied with the proof of claim requirements by giving us written proof covering the occurrence, character and extent of the loss within the time limit stated in the Proof of Loss provision.

2. **Proof of Loss**
   a) Written proof of loss must be given to us within ninety (90) days after the date of loss. However, failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year (1) from the time proof is otherwise required.

   b) The written proof must include a description of the occured loss, the nature and extent of the claimed losses.

   c) Failure to provide such proof within the time required shall not invalidate or reduce a claim if it was not reasonably possible to submit proof within such time, provided that such proof is supplied as soon as reasonably possible, and in no event, except in the absence of legal capacity, no later than one year from the date the proof is required.

OTHER INSURANCE WITH US

If the Insured has coverage in force under one or more policies that are similar to this Policy, all of them issued by the Company, We will pay the applicable benefits under all cancer policies.

PAYMENT OF CLAIMS
If the Primary Insured dies before We have the opportunity to pay the benefit of the policy; this benefit will be paid to the designated beneficiary, if any, or to the succession of the Primary Insured. Any other compensation will be paid to the primary insured.

If any other compensation were payable to the Primary Insured's estate, to an underage child or a person otherwise legally incompetent to execute a valid release, We may pay said benefit, up to an amount not exceeding $1,000 to

any relative of the Primary Insured or the beneficiary who is deemed by Us to be entitled thereto. We will be discharged to the extent of any such payment made in good faith according to this provision.

PHYSICAL EXAMINATIONS AND AUTOPSY

We will have the right and opportunity to examine, at our expense, any person insured under the Policy when and as frequently as needed while she/he is pending a claim in accordance to the Policy provisions and to perform an autopsy upon the death of the insured when its it not prohibited by law.

TIME LIMIT ON CERTAIN DEFENSES

After 2 years of the Policy's Effective Date, no misstatements (except fraudulent misstatements) made by the applicant in the application shall be used to void the Policy or to deny a claim for a loss or disability that begins after that 2-year period.

Statements made by the applicant in this Policy's application will be regarded as representations and not as guarantees. False declarations, omissions, concealment of facts and incorrect statements will not prevent collections in relation to the Policy unless they are: (1) fraudulent, or (2) material for the acceptance of the risk or for the danger We assume, or (3) We, in good faith, would have not issued the Policy or provided coverage for the resulting risk had We learned the correct facts, as requested in the Policy application. When the applicant incurs in any of the above-mentioned acts, collection will be prevented only when the pertinent act or omission would have contributed to the loss in the cause of action.

No claim for loss incurred commencing after 2 year from the Policy's Effective Date shall be reduced or denied based on the fact that, prior to the Policy's Effective Date, a disease or physical condition existed that was not excluded from the coverage by name or specific description, effective on the date of the loss.

TIME LIMIT TO PAY CLAIMS

All indemnities payable by this Policy will be paid upon receipt of written, reliable proof of loss.

UNPAID PREMIUM

When paying a claim in accordance to the Policy provisions, any overdue, unpaid premium may be deducted from said payment.