TRIPLE-S MANAGEMENT CORP
Form S-1
April 27, 2007

As filed with the Securities and Exchange Commission on April 27, 2007
Registration No. 333-_____

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

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FORM S-1
REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

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TRIPLE-S MANAGEMENT CORPORATION
(Exact Name of Registrant as Specified in Its Charter)

Puerto Rico	6324	66-0555678
(State or Other Jurisdiction of Incorporation or Organization)	(Primary Standard Industrial Classification Code Number)	(I.R.S. Employer Identification Number)

1441 F.D. Roosevelt Avenue
San Juan, Puerto Rico, 00920
(787) 749-4949
(Address, Including Zip Code, and Telephone Number, Including Area Code, of Registrant's Principal Executive Offices)

_____

Ramón M. Ruiz-Comas
President and Chief Executive Officer
1441 F.D. Roosevelt Avenue
San Juan, Puerto Rico, 00920
(787) 749-4949
(Name, Address, Including Zip Code, and Telephone Number, Including Area Code, of Agent For Service)

_____

Copies to:

Nicholas A. Kronfeld
Davis Polk & Wardwell
450 Lexington Avenue
New York, New York 10017
(212) 450-4000
Telecopy: (212) 450-3800

William J. Whelan, III
Cravath, Swaine & Moore LLP
825 Eighth Avenue
New York, New York 10019
(212) 474-1000
Telecopy: (212) 474-3700

Approximate date of commencement of proposed sale to the public: As soon as practicable after the effective date of this Registration Statement.

If any of the securities being registered on this form are to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, check the following box. o

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

If this form is a post-effective amendment filed pursuant to Rule 462(d) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. o

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CALCULATION OF REGISTRATION FEE

Title Of Each Class Of Securities To Be Registered	Proposed Maximum Aggregate Offering Price (1)(2)	Amount Of Registration Fee
Class B Common Stock, par value $1.00 per share	$250,000,000	$7,675

(1) Estimated solely for the purpose of computing the amount of the registration fee pursuant to Rule 457(o) under the Securities Act of 1933.

(2) Includes shares issuable to holders of Class B Common Stock without separate consideration in future periods pursuant to certain anti-dilution rights of the shares of Class B Common Stock.

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until the Registration Statement shall become effective on such date as the Commission, acting pursuant to said Section 8(a), may determine.

The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities and it is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED APRIL 27, 2007

Shares

Class B Common Stock

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Prior to this offering, there has been no public market for our common stock. The initial public offering price of our Class B shares is expected to be between $ and $ per share. We intend to apply to list our Class B shares on the New York Stock Exchange under the symbol "GTS."

We are selling shares and the selling shareholders are selling shares. We are not offering or listing our shares of Class A common stock. Upon completion of this offering, assuming the underwriters fully exercise the option to purchase additional shares described below, of our Class B shares, representing % of our share capital, will be held by the public and Class A shares, representing % of our share capital, will be held by our current shareholders. We will not receive any of the proceeds from the sale of shares by the selling shareholders.

Our amended and restated articles of incorporation prohibit any institutional investor from owning 10% or more of our outstanding voting securities, any noninstitutional investor from owning 5% or more of our outstanding voting securities and any person or entity from owning equity securities representing a 20% or more ownership interest in our company. These ownership restrictions will apply to the shares sold in this offering. See "Description of Capital Stock" on page 117 for a more detailed discussion of these restrictions.

The underwriters have an option to purchase up to and additional shares from us and the selling shareholders, respectively, to cover over-allotments of shares.

Investing in our Class B common stock involves risks. See "Risk Factors" on page 9.

	Price to Public	**Underwriting Discounts and Commissions**	**Proceeds to Triple-S Management Corporation**	**Proceeds to the Selling shareholders**
Per Share	$	$	$	$
Total	$	$	$	$

Delivery of the shares of Class B common stock will be made on or about , 2007.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

Joint Book Running Managers

Credit Suisse **UBS Investment Bank**

The date of this prospectus is ..

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You should rely only on the information contained in this prospectus or to which we have referred you. We have not authorized anyone to provide you with information that is different. If anyone provides you with different or inconsistent information, you should not rely on it. This prospectus may only be used where it is legal to sell these securities. The information in this prospectus may only be accurate on the date of this prospectus.

Puerto Rico insurance laws require the prior approval of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance) for (1) any offer to acquire or sell any issued and outstanding voting securities of Triple-S Management Corporation or any of its insurance subsidiaries that constitutes 10% or more of our or our subsidiary's stock, and (2) any solicitation or receipt of funds in exchange for the issuance of new shares of our or our insurance subsidiaries' capital stock. See "Description of Capital Stock."

Dealer Prospectus Delivery Obligation

Until , 2007 (25 days after the commencement of this offering), all dealers that effect transactions in these securities, whether or not participating in this offering, may be required to deliver a prospectus. This is in addition to the dealer's obligation to deliver a prospectus when acting as an underwriter and with respect to unsold allotments or subscriptions.

PROSPECTUS SUMMARY

In this prospectus, "Triple-S", "TSM", the "Company", the "Corporation", "we", "us", and "our" refer to Triple-S Management Corporation, a Commonwealth of Puerto Rico corporation, and, as the context requires, its subsidiaries. References to "shares" or "common stock" refer collectively to our Class A common stock and Class B common stock, unless the context indicates otherwise. All per share amounts in this prospectus have been restated to reflect the 3,000 for one stock split of our common stock to be effected by us on May 1, 2007. This summary highlights information contained elsewhere in this prospectus and may not contain all of the information that may be important to you. You should read this entire prospectus carefully, including the information set forth in "Risk Factors", before making an investment decision.

Our Company

We are the largest managed care company in Puerto Rico, serving approximately one million members across all regions, and hold a leading market position covering approximately 25% of the population. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico and have over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Medicare and Puerto Rico Health Reform (similar to Medicaid) markets.

We serve a full range of customer segments, from corporate accounts, federal and local government employees and individuals to Medicare recipients and Puerto Rico Health Reform (the Reform) enrollees, with a wide range of managed care products. We market our managed care products through both an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force.

We also offer complementary products and services, including life insurance, accident and disability insurance, and property and casualty insurance. As a result of our acquisition of Great American Life Assurance Company of Puerto Rico (GA Life) in January 2006, we are the leading provider of life insurance policies in Puerto Rico.

In the year ended December 31, 2006, we generated total revenue of approximately $1.6 billion, of which approximately 88% was derived from our managed care businesses and 12% from our life insurance and property and casualty insurance businesses.

Our Competitive Strengths

Strong Brand Recognition and Reputation in Puerto Rico. We believe that the strength of the Triple-S brand, which we have built through our longstanding presence in Puerto Rico and our exclusive license to use the Blue Shield mark, gives us a significant competitive advantage. With an operating history of over 45 years, Triple-S is the second largest locally-owned company and one of the most widely recognized brands in Puerto Rico based on several studies conducted in recent years. We have a loyal customer base, with an average yearly customer retention rate of over 90% in our corporate accounts business since 2003. In addition, we believe that our participation in the Blue Cross Blue Shield Association's BlueCard® PPO program, which provides our members with coverage for medical attention throughout the United States, provides a strong competitive advantage because the primary travel destination of Puerto Rico residents is the continental United States.

Leading Market Positions with Broad Range of Managed Care Products. We are the largest managed care company in Puerto Rico in terms of market share, with approximately 25% of the market (in terms of premiums written) as of December 31, 2006. We enjoy leading market positions in many customer segments, including corporate accounts, Medicare Supplement, federal government employees and individual accounts. We offer customized managed care products including health maintenance organizations (HMOs) to our Medicare Advantage

and Reform customers and preferred provider organizations (PPOs) on both a fully insured and self-funded basis to our commercial customers, and as a result believe that we have the most comprehensive range of managed care products in Puerto Rico.

Broad Provider Networks. We believe we have the broadest geographic coverage of any managed care insurer in Puerto Rico, including hospital and physician networks consisting of some of the most well-recognized physicians and hospitals in Puerto Rico. This is particularly important to large corporate accounts, which typically require that a single insurer cover all of their employees. For example, we believe that a number of corporate clients have contracted with us because we offer an island-wide provider network, as well as access to U.S. providers through the BlueCard program. We maintain strong provider relationships in all of our markets.

Commitment to Quality Care. We have demonstrated our commitment to quality care, implementing a number of disease management and health education programs, including programs that target asthma, diabetes, heart failure, hypertension and selected nutrition-related conditions, as well as a prenatal program and a medication therapy management program. We have had a contract with McKesson Health Solutions since 1998 pursuant to which they provide to us 24 hour nurse triage (for all of our customer sectors) and utilization management program services for the Reform segment, Medicare Advantage programs and certain commercial customers.

Strong Complementary Businesses. To enhance our relationships with managed care customers, we offer life, disability, and property and casualty insurance products designed to complement the sale of our managed care products and services. As a result of our acquisition of GA Life in January 2006, we are the leading provider of life insurance policies in Puerto Rico. Our broad range of managed care and complementary products provides us with significant opportunities to develop additional points of distribution, particularly among the insurance agencies of Puerto Rico-based financial institutions. In addition, approximately 45% of the sales agents employed by us are licensed to sell both life insurance and managed care products.

Proven and Experienced Management Team. We have been a market leader in managed care in Puerto Rico for over 45 years and believe that the extensive experience of our management team provides us with a strong competitive advantage. We also have a strong record of management continuity, which has allowed for efficiency of operations and retention of valuable knowledge. Our senior management team has an average of 13 years of experience at Triple-S.

Our Strategy

Expand Operating Margins and Realize Operating Efficiencies. Our managed care business was exempt from Puerto Rico income taxes from 1979 until 2003, and was operated as if it was a not-for-profit until that time, as required by the terms of the exemption. Accordingly, beginning in 2004, we increased our efforts to manage medical costs and generate profits as a for-profit managed care company. Even more recently, in anticipation of becoming a public company and to compete more effectively, we have begun to implement or, in some cases, expect to implement, a number of initiatives to reduce utilization and reduce overall medical costs. Some of these initiatives include:

- re-pricing unprofitable customer contracts or permitting such contracts to lapse;
- refining our provider network;
- expanding existing Reform sector disease management programs to other sectors, such as commercial and Medicare;
- implementing radiology benefits management initiatives to reduce spending on high-tech imaging; and
- refining our pharmacy network.

We believe that increased scale in each of our segments will provide efficiencies and greater opportunities to sustain profitable growth.

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Grow Medicare Advantage Business. We intend to leverage our brand recognition to further penetrate the Medicare Advantage (a managed care program available to Medicare beneficiaries) market. We entered the Medicare Advantage market in 2005 and as of December 31, 2006 had a market share of approximately 7.0% of the Medicare Advantage market in Puerto Rico. As of December 31, 2006, Puerto Rico had over 600,000 persons eligible for Medicare. Puerto Rico is a particularly attractive growth opportunity, as the population over the age of 65 is expected to grow at an average of 2.4% per annum between 2005 and 2010, as compared to 1.7% in the continental U.S., according to the Puerto Rico Planning Board and U.S. Census Bureau. We believe our Medicare Advantage business will continue to grow, driven by the following:

- Leveraging our position in the Reform business to expand our Medicare Advantage coverage of dual-eligibles (individuals who qualify for both Medicare and Reform benefits). Approximately 31% of Medicare beneficiaries in Puerto Rico are considered dual-eligibles.

- Targeting the conversion of Medicare Supplement members (members with Medicare coverage who purchase supplemental coverage to pay for Medicare deductibles and co-insurance and additional non-Medicare covered benefits) to the more comprehensive benefits structure offered by, and higher revenue generating, Medicare Advantage products. We introduced for the January 2007 enrollment period a variety of new Medicare Advantage products and benefits, including an integrated prescription drug plan and a commercial Medicare Advantage HMO product. In addition, we expect to grow our Medicare Advantage business through the conversion of Medicare Part D prescription drug plan members to Medicare Advantage products.

Develop New Products to Attract and Retain Customers. We intend to leverage our strong brand recognition and extensive history to drive profitable growth by introducing new products to the Puerto Rico market. Our particular focus is on the commercial sector within our managed care segment, where we intend to introduce new products such as reduced benefits packages targeted at part-time employees, a new preferred provider network targeted at low salary industries and the uninsured, various new products for individual markets, a lower cost limited provider network and other new group products. We believe that such new products will also help us to retain existing customers by meeting their evolving needs for managed care products. We believe that Puerto Rico is a highly cost-effective market in which to introduce new products because of its dense population.

Pursue Cross-Selling and Related Opportunities. To expand our relationships with our managed care customers, we intend to capitalize on cross-selling opportunities by taking advantage of our leading brand name and using our internal and external sales forces to sell both managed care and complementary products such as life, disability, and property and casualty insurance. Only 13 of our 30 largest corporate customers currently purchase both managed care and complementary products from us. We believe that our acquisition of GA Life, through which we acquired individual life insurance products and a substantial sales force, will allow us to further capitalize on cross-selling opportunities. We have established relationships with leading financial institutions in Puerto Rico which we believe will allow us to develop our business opportunities in property and casualty and life insurance products through these institutions' agency operations.

Disciplined Acquisition Strategy. We believe that profitable growth, both organic and through acquisitions, is an important part of our business. Increased scale can allow us to improve operating margins, while maintaining competitive prices for our products. We believe that we have the ability to efficiently integrate acquisitions, as evidenced by our successful integration of GA Life. We intend to focus on acquiring managed care plans that expand our product offering. We also may seek to expand our business outside Puerto Rico in the Caribbean or the continental United States, with a particular focus on Hispanic communities, although we currently are not able to sell our managed care products in these areas under the Blue Shield name and will not be able to do so in any area in which a licensee already operates. In addition, we believe that Puerto Rico's Reform managed care model is similar to that of many U.S. states' Medicaid programs. We may seek to leverage our expertise in the Reform business by expanding into the U.S. Medicaid managed care market via a joint venture with a U.S. managed care company or an acquisition.

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History and Corporate Information

We have been owned since our founding in 1959 by doctors and dentists that are or were providers in our managed care networks. We were incorporated under the laws of Puerto Rico in January 1999 as part of a reorganization pursuant to which our current holding company structure was created. The purpose of the reorganization was to increase our flexibility, as holding companies are not insurance companies within the meaning of the Puerto Rico Insurance Code and are therefore generally not directly subject to the limitations applicable to insurance companies.

We operate our managed care business through our subsidiary Triple-S, Inc. (TSI), our life insurance business through our subsidiary GA Life and our property and casualty insurance business through our subsidiary Seguros Triple-S, Inc. (STS). Each of our operating subsidiaries is a regulated entity under the laws of Puerto Rico.

Our principal offices are located at 1441 F.D. Roosevelt Avenue, San Juan, Puerto Rico and our telephone number is (787) 749-4949. Our website address is www.ssspr.com. The information contained therein is not incorporated by reference in this prospectus.

THE OFFERING

Common stock offered by	
Us	shares of Class B common stock
Selling shareholders	shares of Class B common stock
Total	shares of Class B common stock
Over-allotment option	
Us	shares of Class B common stock
Selling shareholders	shares of Class B common stock
Total	shares of Class B common stock
Common stock to be outstanding after this offering	shares (shares if the over-allotment option is exercised in full), consisting of shares of Class A common stock and shares of Class B common stock (shares of Class A common stock and shares of Class B common stock if the over-allotment option is exercised in full)
Use of Proceeds	We estimate that our proceeds from this offering, after deducting underwriting discounts and commissions and estimated offering expenses payable by us, will be approximately $ million, assuming the shares of Class B common stock are offered at $ per share, which is the midpoint of the estimated offering price range set forth on the cover page of this prospectus. We intend to use the net proceeds from this offering to repay a portion of our outstanding indebtedness, and for general corporate purposes, including working capital and possible acquisitions and investments. We will not receive any proceeds from the sale of shares by the selling shareholders. See "Use of Proceeds."
Proposed New York Stock Exchange Symbol	"GTS"

Unless otherwise indicated, the information in this prospectus:

- assumes an initial public offering price of $ per share (the midpoint of the price range set forth on the front cover of this prospectus);
- reflects the 3,000 for one stock split to be effected by us on May 1, 2007, all of which will become Class A common stock upon consummation of this offering, with the exception of the shares to be sold in this offering, which will become Class B shares;
- assumes no exercise of the underwriters' option to purchase up to and additional shares from us and the selling shareholders, respectively, to cover over-allotments.

Risk Factors

Investing in our common stock involves substantial risk. Please read "Risk Factors" beginning on page 9 for a discussion of certain factors you should consider in evaluating an investment in our common stock.

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Anti-Dilution Protections

For a period of five years from the completion of this offering, subject to extension or shortening under certain circumstances, each holder of our Class B shares will benefit from anti-dilution protections provided in our amended and restated articles of incorporation, pursuant to which each holder of Class B shares will be entitled to receive, upon any issuance of our shares to certain potential claimants at a price or prices below the then prevailing market price, such number of additional Class B shares as is necessary to maintain the approximate market value of such holder's investments in us as of the date immediately prior to the first public announcement of the proposed issuance of shares to such claimants. See "Risk Factors - Risks Relating to Our Capital Stock" and "Description of Capital Stock." We believe that these protections should be sufficient to prevent dilution of the Class B shares resulting from the issuance of shares to claimants at a price or prices below the then prevailing market prices, but cannot provide assurances that the protections will be effective in all potential scenarios.

SUMMARY CONSOLIDATED FINANCIAL AND ADDITIONAL DATA

The table below provides a summary of our historical consolidated financial data for each of the three years in the period ended December 31, 2006. We derived the statement of earnings data for the three years in the period ended December 31, 2006, and the balance sheet data as of December 31, 2006 and 2005 from our audited consolidated financial statements included elsewhere in this prospectus.

You should read this summary consolidated financial data together with "Selected Consolidated Financial and Additional Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements and accompanying notes included elsewhere in this prospectus.

Until October 31, 2006, we had contracts with the government of the Commonwealth of Puerto Rico (the government of Puerto Rico) to be the Reform insurance carrier for three of the eight geographical areas into which Puerto Rico is divided for purposes of the Reform. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. The contracts for the other two regions were renewed for an additional one-year period. The premiums earned, net and operating income related to the operations of the Metro-North region for the year ended December 31, 2006 amounted to $161.6 million and $5.4 million, respectively, and $200.9 million and $3.5 million, respectively, for the year ended December 31, 2005.

	Year Ended December 31,		
(Dollars in millions, except per share data)	**2006[1]**	**2005**	**2004**
Statement of Earnings Data			
Revenues:			
Premiums earned, net	$ 1,511.6	$ 1,380.2	$ 1,299.0
Administrative service fees	14.1	14.4	9.2
Net investment income	42.7	29.1	26.8
Total operating revenues	1,568.4	1,423.7	1,335.0
Net realized investment gains	0.8	7.2	11.0
Net unrealized investment gain (loss) on trading securities	7.7	(4.7)	3.0
Other income, net	2.3	3.7	3.4
Total revenues	1,579.2	1,429.9	1,352.4
Benefits and expenses:			
Claims incurred	1,259.0	1,208.3	1,115.8
Operating expenses	236.1	181.7	171.9
Total operating costs	1,495.1	1,390.0	1,287.7
Interest expense	16.6	7.6	4.6
Total benefits and expenses	1,511.7	1,397.6	1,292.3
Income before taxes	67.5	32.3	60.1
Income tax expense	13.0	3.9	14.3
Net income	$ 54.5	$ $28.4	$ $45.8
Weighted average number of shares outstanding	8,911	8,904	8,919
Weighted average number of shares outstanding giving effect to 3,000-for-one stock split	26,733,000	26,712,000	26,757,000
Basic net income per share	$ 6,120	$ 3,193	$ 5,135
	$ 2.04	$ 1.06	$ 1.71

Basic net income per share giving effect to 3,000-for-one stock split	

(Dollars in millions, except per share data)	As of December 31, 2006[1]	2005	2004
Balance Sheet Data			
Cash and cash equivalents	$81.3	$49.0	$35.1
Total assets	1,345.5	1,137.5	919.7
Long-term borrowings	183.1	150.6	95.8
Total shareholders' equity	342.6	308.7	301.4

	Year Ended December 31, 2006	2005	2004
Additional Managed Care Data [2]			
Medical loss ratio	87.6%	90.3%	88.3%
Operating expense ratio	11.5%	10.8%	10.8%
Medical membership (period-end)	979,506	1,252,649	1,236,108

(1) On January 31, 2006, we completed the acquisition of GA Life. The results of operations and financial condition of GA Life are included in this table for the period following the effective date of the acquisition. See note 3 to the audited consolidated financial statements included elsewhere herein.

(2) Does not reflect inter-segment eliminations.

RISK FACTORS

You should carefully consider the following risks and all other information set forth in this prospectus before investing. These risks and other factors could materially affect our business, results of operations or financial condition and cause the trading price of our common stock to decline. You could lose part or all of your investment.

Risks Relating to our Capital Stock

Certain of our current and former providers may bring materially dilutive claims against us.

Beginning with our founding in 1959 and until 1994, we encouraged, and at times required, the doctors and dentists that comprised our provider network to acquire our shares. Between approximately 1985 and 1994, our predecessor managed care subsidiary, Seguros de Servicios de Salud de Puerto Rico, Inc. (SSS) generally entered into an agreement with each new physician or dentist who joined our provider network to sell the provider shares of SSS at a future date (each a share acquisition agreement). These agreements were necessary because there were not enough authorized shares of SSS available during this period and afterwards for issuance to all new providers. Each share acquisition agreement committed SSS to sell, and each new provider to purchase, five $40-par-value shares of SSS at $40 per share after SSS had increased its authorized share capital in compliance with the Puerto Rico Insurance Code and was in a position to issue new shares. Despite repeated efforts in the 1990s, SSS was not successful in obtaining shareholder approval to increase its share capital, other than in connection with our reorganization in 1999, when SSS was merged into a newly-formed entity having authorized capital of 25,000 $40-par-value shares, or twice the number of authorized shares of SSS. SSS's shareholders and the Commissioner of Insurance did not, however, authorize the issuance of the newly formed entity's shares to providers or any other third party. In addition, subsequent to the reorganization, TSM's shareholders did not approve attempts to increase TSM's share capital in 2002 and 2003.

Notwithstanding the fact that TSI and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into share acquisition agreements may claim that the share acquisition agreements entitle them to acquire shares of TSI or TSM at a subscription price equivalent to that provided for in the share acquisition agreements. SSS entered into share acquisition agreements with approximately 3,000 providers, the substantial majority of whom never came to own shares of SSS. Such share acquisition agreements provide for the purchase and sale of approximately 15,000 shares of SSS. Were TSI or TSM required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this prospectus, although no judicial claims of this nature have been commenced, we have received inquiries with respect to at least approximately 500 shares (or 1,500,000 shares if effect were given to the potential claims in respect of such 500 shares were multiplied on the same basis as the 3,000 -for -one stock split to be effected on May 1, 2007) under share acquisition agreements.

Management has been advised by Puerto Rico counsel that, on the basis of a reasoned analysis, while the matter is not free from doubt and there are no applicable controlling precedents, we should prevail if litigation of these claims were to be commenced by providers because, among other defenses, the condition precedent to SSS's obligations under the share acquisition agreements never occurred, and any obligation it or its subsidiaries or predecessors may have had under the share acquisition agreements should be understood to have expired prior to our corporate reorganization, which took effect in 1999, although the share acquisition agreements do not expressly provide for any expiration.

Management believes we should prevail in litigation if any judicial claims are commenced with respect to these matters; however, we cannot predict the outcome of any such litigation, including with respect to the magnitude of any claims that may be asserted by any plaintiff, and the interests of our shareholders could be materially diluted to

the extent that claims under the share acquisition agreements are successful. The Class B shares we are offering with this prospectus include anti-dilution protections designed to offset the dilutive effect of the issuance of shares in respect of such claims at below market prices on the Class B of shares during a period of up to five or more years from the date that this offering is completed. See “Description of Capital Stock.”

Heirs of certain of our former shareholders may bring materially dilutive claims against us.

For much of our history, TSM and its predecessor entities have restricted the ownership or transferability of their shares, including by reserving to TSM or its predecessors a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, TSM and its predecessors, consistent with the requirements of their bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, we anticipate that some former shareholders' heirs who were not eligible to own or be transferred shares because they were not physicians or dentists at the time of their purported inheritance ("non-medical heirs"), may claim an entitlement to TSM shares or to damages in respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 non-medical heirs who may claim to have inherited up to 3,500 shares (or 10,500,000 shares, after giving effect to the 3,000 for one stock split to be effected by us on May 1, 2007), although no judicial claims in this regard have ever been initiated. As of the date of this prospectus, we have received inquiries from non-medical heirs with respect to approximately 420 shares (or 1,260,000 shares, after giving effect to the 3,000 for one stock split to be effected by us on May 1, 2007).

Management believes that we should generally prevail against any such claims if brought; however, management cannot predict the outcome of any eventual litigation regarding these non-medical heirs. The interests of our existing shareholders could be materially diluted to the extent that any such claims are successful. The Class B shares we are offering with this prospectus include anti-dilution protections designed to offset the dilutive effect of the issuance of any shares in respect of such claims at below market prices on the Class B shares during a period of five years from the date that this offering is completed. See "Description of Capital Stock."

The dual class structure may not successfully protect against significant dilution of your Class B shares.

We designed the dual class structure of capital stock described in "Description of Capital Stock" to maintain the value of the ownership interest in TSM represented by the Class B shares immediately prior to the announcement of any proposed issuance of shares that we are required to issue with respect to a claim against us under any share acquisition agreement or by a non-medical heir. We believe that this mechanism will effectively protect investors in our Class B shares against any potential dilution from the issuance of any shares in respect of such claims at below market prices, but we cannot assure you that this mechanism will be effective under all circumstances. While we expect to prevail against any such claims brought against us and, to the extent that we do not prevail, would expect to issue Class A shares in respect of any such claim, there can be no assurance that the claimants in any such lawsuit will not seek to acquire Class B shares. The issuance of a significant number of Class B shares, if followed by a material further issuance of shares to separate claimants, could impair the effectiveness of the anti-dilution protections of the Class B shares. In addition, we cannot assure you that the anti-dilution protections afforded our Class B shares will not be challenged by share acquisition providers and/or non-medical heir claimants to the extent that these protections limit the percentage ownership of TSM that may be acquired by such claimants. We believe that such a challenge should not prevail, but cannot provide any assurances of the outcome.

In the event that claimants seek to acquire shares of our managed care subsidiary, TSI, we will not be able to prevent dilution of the value of the indirect ownership of the net assets of TSI represented by the Class B shares to the extent that such claimants are awarded a number of shares at less than fair value that dilutes TSM's interest in TSI to a percentage lower than the percentage of Class B shareholder ownership of TSM. Finally, the anti-dilution protection afforded by the dual class structure may cease to be of further effect five years following completion of this offering, at which time all remaining Class A shares may, at the discretion of our board of directors, be converted into Class B shares even if we have not resolved all claims against us by such time.

Risks Relating to our Business

Our inability to contain managed care costs may adversely affect our business and profitability.

Substantially all of our managed care revenue is generated by premiums consisting of monthly payments per member that are established by contracts with our commercial customers, the government of Puerto Rico (for our Reform program) or the Centers for Medicare and Medicaid Services (CMS) (for our Medicare Advantage plans), all of which are typically renewable on an annual basis. If our medical expenses exceed our estimates, except in

very limited circumstances or as a result of risk score adjustments for member acuity, we will be unable to increase the premiums we receive under these contracts during the then-current terms. As a result, our profitability in any year depends, to a significant degree, on our ability to adequately predict and effectively manage our medical expenses related to the provision of managed care services through underwriting criteria, medical management, product design and negotiation of favorable provider contracts with hospitals, physicians and other health care providers. The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Government-imposed limitations on Medicare and Reform reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Also, we have in the past and may in the future enter into new lines of business in which it may be difficult to estimate anticipated costs. Numerous factors affecting the cost of managed care, including changes in health care practices, inflation, new technologies such as genetic laboratory screening for diseases including breast cancer, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment including the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as others, may adversely affect our ability to predict and manage managed care costs, as well as our business, financial condition and results of operations.

Our inability to implement increases in premium rates on a timely basis may adversely affect our business and profitability.

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at the time of policy renewal to obtain more favorable premiums. Future Medicare and Reform premium rate levels may be affected by continuing government efforts to contain medical expense or other federal budgetary constraints. In particular, the government of Puerto Rico has adopted several measures to control Reform expenditures, such as closer and continuous scrutiny of participants' eligibility, redesign of benefits, co-payments, deductibles, and requiring the establishment of disease management programs. Changes in the Medicare and Reform program, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare and the Reform. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

Our profitability may be adversely affected if we are unable to maintain our current provider agreements and to enter into other appropriate agreements.

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other managed care providers. We face heavy competition from other managed care plans to enter into contracts with hospitals, physicians and other providers in our provider networks. Consolidation in our industry, both on the provider side and on the managed care side, only exacerbates this competition. Currently certain providers are pressing for legislation that would allow providers to negotiate service fees by group. The failure to maintain or to secure new cost-effective managed care provider contracts may result in a loss in membership or higher medical costs. In addition, our inability to contract with providers could adversely affect our business.

A reduction in the enrollment in our managed care programs could have an adverse effect on our business and profitability.

A reduction in the number of enrollees in our managed care programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; reductions in workforce by existing customers; negative publicity and news coverage; failure to maintain the Blue Shield license; reductions in the number of persons enrolled in or eligible for Medicare or the Reform; and any general economic downturn that results in business failures.

We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business.

Our managed care business participates in government contracts that generate a significant amount of our consolidated premiums earned, net, as follows:

- *Reform Program.* We participate in the government of Puerto Rico Health Reform to provide health coverage to medically indigent citizens in Puerto Rico. Our results of operations have depended to a significant extent on our participation in the Reform program. During each of 2006, 2005 and 2004, the Reform program has accounted for 30.2%, 37.0% and 37.3%, respectively, of our consolidated premiums earned, net. During these periods, we were the sole Reform provider in three of the eight Reform regions in Puerto Rico. Since we obtained our first Reform contract in 1995, we have been the sole provider for two to three regions each year. The contract for each geographical area is subject to termination in the event of any non-compliance by our managed care subsidiary which is not corrected or cured to the satisfaction of the government entity overseeing the Reform, or on 90 days' prior written notice in the event that the government determines that there is an insufficiency of funds to finance the Reform. These contracts have one-year terms and expire on September 30 of each year. Upon the expiration of the contract for a geographical area, the government of Puerto Rico usually commences an open bidding process for such area. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. During each of 2006, 2005 and 2004, this region accounted for 10.7%, 14.6% and 14.2%, respectively, of our consolidated premiums earned, net and 7.3%, 10.3% and 9.3%, respectively, of our consolidated operating income. We intend to continue to participate in the Reform program, but we may not be able to retain the right to service a particular geographical area in which we currently operate after the expiration of our current or any future contracts.

- *Medicare Advantage:* We provide services through our Medicare Advantage health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if any of these contracts are terminated, our business would be materially impaired. Contracts with CMS represented 11.3% of our consolidated premiums earned, net and 45.9% of our consolidated operating income during 2006 and may in the future represent a greater percentage of our results.

- *Commercial:* Our managed care subsidiary is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the U.S. Office of Personnel Management (OPM) that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. During 2006, 2005, and 2004, premiums generated under this contract represented 7.5%, 8.2% and 8.3% of our consolidated premiums earned, net, respectively, and 1.2%, 2.4% and 1.6% of our consolidated operating income, respectively.

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our premiums would be materially adversely affected. The further loss or non-renewal of either of our Reform contracts could have a material adverse effect on our operating results and could result in the downsizing of certain personnel, the cancellation of lease agreements of certain premises and of certain contracts, and severance payments, among others.

A change in our managed care product mix may impact our profitability.

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than administrative services only (ASO) products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our commercial customers of moving from fully-insured plans to ASO, or self-funded, arrangements. In addition, the government of Puerto Rico began a pilot project in 2003 for the Reform in one of the eight geographical areas under which it contracted services on an ASO basis for certain members instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. There can be no assurance that the government will not implement such a program in areas served by us. As of December 31, 2006, 83.9% of our managed care customers had fully insured arrangements and 16.1% had ASO arrangements, as

compared to approximately 87.8% and 12.2%, respectively, as of December 31,

2005. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

Our failure to accurately estimate incurred but not reported claims would affect our reported financial results.

A portion of the claim liabilities recorded by our insurance segments represents an estimate of amounts needed to pay and adjust anticipated claims with respect to insured events that have occurred, including events that have not yet been reported to us. These amounts are based on estimates of the ultimate expected cost of claims and on actuarial estimation techniques. Judgment is required in actuarial estimation to ascertain the relevance of historical payment and claim settlement patterns under each segment's current facts and circumstances. Accordingly, the ultimate liability may be in excess of or less than the amount provided. We regularly compare prior period liabilities to re-estimated claim liabilities based on subsequent claims development; any difference between these amounts is adjusted in the operations of the period determined. Additional information on how each reportable segment determines its claim liabilities, and the variables considered in the development of this amount, is included elsewhere in this prospectus under "Management's Discussion and Analysis of Financial Condition and Results of Operation — Critical Accounting Policies and Estimates." Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimates based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations.

We are a party to license agreements with the Blue Cross Blue Shield Association (BCBSA) which entitle us to the exclusive use of the Blue Shield name and mark in Puerto Rico. We believe that the Blue Shield name and mark are valuable identifiers of our products and services in the marketplace. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations.

Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Shield name and mark. Failure to comply with any of these requirements and restrictions could result in a termination of the license agreements. The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to permit its provider networks to contract with insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations.

Upon any event causing termination of the license agreements, we would no longer have the right to use the Blue Shield name and mark in Puerto Rico. Furthermore, the BCBSA would be free to issue a license to use the Blue Shield name and mark in Puerto Rico to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of the license agreements could have a material adverse effect on our business, financial condition and results of operations.

In addition, the BCBSA requires us to comply with certain specified levels of risk based capital (RBC). RBC is designed to identify weakly capitalized companies by comparing each company's adjusted surplus to its required

surplus (the RBC ratio). Although we are currently in compliance with these requirements, we may be unable to continue to comply in the future. Failure to comply with these requirements could result in the revocation or loss of our BCBSA license.

Upon termination of a license agreement, the BCBSA would impose a “Re-establishment Fee” upon us, which would allow the BCBSA to “re-establish” a Blue Shield presence in the vacated service area with another managed

care company. Through December 31, 2006 the fee is set at $83.41 per licensed enrollee. If the re-establishment fee was applied to our total Blue Shield enrollees, we would be assessed approximately $81.7 million by the BCBSA.

See “Business—Blue Shield License” for more information.

Our ability to manage our exposure to underwriting risks in our life insurance and property and casualty insurance businesses depends on the availability and cost of reinsurance coverage.

Reinsurance is the practice of transferring part of an insurance company’s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. In 2006, 41.3%, or $65.7 million, of the premiums written in the property and casualty insurance segment and 10.6%, or $9.7 million, of the premiums written in the life insurance segment were ceded to reinsurers. The availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or to obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

It is also possible that the losses we experience on insured risks for which we have obtained reinsurance will exceed the coverage limits of the reinsurance. If the amount of our reinsurance coverage is insufficient, our insurance losses could increase substantially.

If our reinsurers do not pay our claims or do not pay them in a timely manner, we may incur losses.

We are subject to loss and credit risk with respect to the reinsurers with whom we deal because buying reinsurance does not relieve us of our liability to policyholders. In accordance with general industry practices, our property and casualty and life insurance subsidiaries annually purchase reinsurance to lessen the impact of large unforeseen losses and mitigate sudden and unpredictable changes in our net income and shareholders equity. In the event that all or any of the reinsurance companies are unable to meet their obligations under existing reinsurance agreements or pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their financial obligations to us, our insurance losses would increase, which would negatively affect our financial condition and results of operations.

A downgrade in our A.M. Best rating or our inability to increase our A.M. Best rating could affect our ability to write new business or renew our existing business in our property and casualty segment.

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In July 2006, as a result of the additional indebtedness we incurred in connection with the acquisition of GA Life, A.M. Best maintained our property and casualty insurance subsidiary’s rating of A- (the fourth highest of A.M. Best’s 16 financial strength ratings) but changed the outlook to negative. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary’s rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

Significant competition could negatively affect our ability to maintain or increase our profitability.

Managed Care

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided,

speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of managed care companies. In addition, the managed care market in Puerto Rico, other than the Medicare Advantage market, is mature. According to the U.S. Census Bureau, Puerto Rico's population grew by 0.4% between July 2004 and 2005, less than half the national population rate growth of 0.9% during the same period. As a result, in order to increase our profitability we must increase our membership in the new Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several new managed care plans and other entities have been awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans and entered that market in 2006. We anticipate that these other plans will aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans. The recently adopted Tax Relief and Health Care Act of 2006 allows Medicare beneficiaries to enroll throughout the year only in Medicare Advantage plans that do not offer Part D prescription drug coverage. Since we do offer such coverage, we can only enroll new Medicare Advantage members between November 15 and December 31 each year, thus placing us at a competitive disadvantage.

Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. Some of our competitors are larger and have greater financial and other resources than we do. We may have difficulty competing with larger managed care companies, which can create downward price pressures on premium rates. We may not be able to compete successfully against current and future competitors. In addition, our rights under the BCBSA license only extend to the use of the "Blue Shield" mark in Puerto Rico. The exclusive right to use the "Blue Cross" mark in Puerto Rico is currently held by a relatively small company.

Future legislation at the federal and local levels also may result in increased competition in our market. While we do not anticipate that any of the current legislative proposals of which we are aware would increase the competition we face, future legislative proposals, if enacted, might do so.

Complementary Products

The property and casualty insurance market in Puerto Rico is extremely competitive. Due to the relatively low level of economic growth in Puerto Rico, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. We also face heavy competition in the life insurance market.

We believe these trends will continue. There can be no assurance that these competitive pressures will not adversely affect our business, financial condition and results of operations.

As a holding company, we are largely dependent on rental payments, dividends and other payments from our subsidiaries, although the ability of our regulated subsidiaries to pay dividends or make other payments to us is subject to the regulations of the Commissioner of Insurance, including maintenance of minimum levels of capital, as well as covenant restrictions in their indebtedness.

We are a holding company whose assets include, among other things, all of the outstanding shares of common stock of our subsidiaries, including our regulated insurance subsidiaries. We principally rely on rental income and dividends from our subsidiaries to fund our debt service, dividend payments and operating expenses, although our subsidiaries do not declare dividends every year. We also benefit to a lesser extent from income on our investment portfolio.

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. These regulations, among other things, require insurance companies to maintain certain levels of capital which range by type of insurance from $1.0 million to $3.0 million, thereby restricting the amount of earnings that can be distributed. Our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, if any, business and other legal restrictions. Furthermore, creditors of our subsidiaries have a superior claim to such subsidiaries' assets. Our subsidiaries may not be able to pay dividends or otherwise contribute or distribute funds to us in an amount sufficient for us to meet our financial obligations. In addition, from time to time, we may find it necessary to provide financial assistance, either through subordinated loans or capital infusions to our subsidiaries.

In addition, we are subject to RBC requirements by the BCBSA. See "— The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations."

Our results may fluctuate as a result of many factors, including cyclical changes in the insurance industry.

Results of companies in the insurance industry, and particularly the property and casualty insurance industry, historically have been subject to significant fluctuations and uncertainties. The industry's profitability can be affected significantly by:

- rising levels of actual costs that are not known by companies at the time they price their products;
- volatile and unpredictable developments, including man-made and natural catastrophes;
- changes in reserves resulting from the general claims and legal environments as different types of claims arise and judicial interpretations relating to the scope of insurers' liability develop; and
- fluctuations in interest rates, inflationary pressures and other changes in the investment environment, which affect returns on invested capital.

Historically, the financial performance of the insurance industry has fluctuated in cyclical periods of low premium rates and excess underwriting capacity resulting from increased competition, followed by periods of high premium rates and a shortage of underwriting capacity resulting from decreased competition. Fluctuations in underwriting capacity, demand and competition, and the impact on us of the other factors identified above, could have a negative impact on our results of operations and financial condition. We believe that underwriting capacity and price competition in the current market is increasing. This additional underwriting capacity may result in increased competition from other insurers seeking to expand the kinds or amounts of business they write or cause some insurers to seek to maintain market share at the expense of underwriting discipline. We may not be able to retain or attract customers in the future at prices we consider adequate.

If we do not effectively manage the growth of our operations we may not be able to achieve our profitability targets.

Our growth strategy includes enhancing our market share in Puerto Rico, entering new geographic markets, introducing new insurance products and programs, further developing our relationships with independent agencies or brokers and pursuing acquisition opportunities. Our strategy is subject to various risks, including risks associated with our ability to:

- identify profitable new geographic markets to enter;
- operate in new geographic areas, as we have very limited experience operating outside Puerto Rico;
- obtain licenses in new geographic areas in which we wish to market and sell our products;
- successfully implement our underwriting, pricing, claims management and product strategies over a larger operating region;
- properly design and price new and existing products and programs and reinsurance facilities for markets in which we have no direct experience;

- identify, train and retain qualified employees;
- identify, recruit and integrate new independent agencies and brokers and expand the range of Triple-S products carried by our existing agents and brokers;
- develop a network of physicians, hospitals and other managed care providers that meets our requirements and those of applicable regulators; and

- augment our internal monitoring and control systems as we expand our business.

We also may encounter difficulties in the implementation of our growth strategies. For instance, our BCBSA license entitles us to use the Blue Shield name only in Puerto Rico. We currently are not able to use the Blue Shield name in areas outside Puerto Rico. In addition, we may enter into markets or product lines in which we have little or no prior experience. For example, we plan to expand our operations outside Puerto Rico and to expand our property and casualty insurance segment through the establishment of an auto preferred rate insurance company, which will write personal auto policies at discounted rates.

Any such risks or difficulties could limit our ability to implement our growth strategies or result in diversion of senior management time and adversely affect our financial results.

We may be subject to regulatory and investigative proceedings, which may find that our policies, procedures and contracts do not fully comply with complex and changing healthcare regulations.

The Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, including but not limited to CMS, the Office of the Inspector General of the U.S. Department of Health and Human Services, the Office of Civil Rights, the U.S. Department of Justice, and the Office of Personnel Management, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. We may become the subject of regulatory or other investigations or proceedings brought by these authorities, and our compliance with and interpretation of applicable laws and regulations may be challenged. In addition, our regulatory compliance may also be challenged by private citizens under the "whistleblower provisions" of applicable laws. The defense of any such challenge could result in substantial cost and a diversion of management's time and attention. Thus, any such challenge could have a material adverse effect on our business, regardless of whether it ultimately is successful. If we fail to comply with any applicable laws, or a determination is made that we have failed to comply with these laws, our financial condition and results of operations could be adversely affected.

An adverse review, audit or an investigation could result in one or more of the following:

- recoupment of amounts we have been paid pursuant to our government contracts;
- mandated changes in our business practices;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key employees;
- loss of our right to participate in Medicare, the Reform or other federal or local programs;
- damage to our reputation;
- increased difficulty in marketing our products and services;
- inability to obtain approval for future services or geographic expansions; and
- loss of one or more of our licenses to act as an insurance company, preferred provider or managed care organization or other licensed entity or to otherwise provide a service.

Our failure to maintain an effective corporate compliance program may increase our exposure to civil damages and penalties, criminal sanctions and administrative remedies, such as program exclusion, resulting from an adverse review. Any adverse review, audit or investigation could reduce our revenue and profitability and otherwise adversely

affect our operating results.

As a Medicare Advantage program participant, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties, and our Medicare Advantage contracts may be terminated.

The laws and regulations governing Medicare Advantage program participants are complex, subject to interpretation and can expose us to penalties for non-compliance. If we fail to comply with these laws and regulations, we could be subject to criminal fines, civil penalties or other sanctions, including the termination of our Medicare Advantage contracts.

The revised rate calculation system for Medicare Advantage established by the Medicare Modernization Act (MMA) could reduce our profitability.

Effective January 1, 2006, a revised rate calculation system based on a competitive bidding process was instituted for Medicare Advantage managed care plans, including our Medicare Selecto and Medicare Optimo plans. The statutory payment rate was relabeled as the benchmark amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. If the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 75% of the amount by which the benchmark exceeds the bid. However, these rebates can only be used to enhance benefits or lower premiums and co-pays for plan members. If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability.

Furthermore, the Deficit Reduction Act of 2005 (DRA) signed by the President on February 8, 2006, directs CMS to conduct an analysis of fee-for-service provider (a provider who receives payment for services based on actual services provided to Medicare beneficiaries and a contractually mandated or CMS-mandated fee schedule) and Medicare Advantage plan treatment and coding practices (methods of documenting medical services provided to and diagnoses of members) and to incorporate any identified differences into benchmark calculations no later than 2008. This revised rate calculation system established by the MMA and amended by the DRA is likely to eventually result in reduced Medicare Advantage payment rates, which could reduce our revenues and cause our profitability to decline. We may also face the risk of reduced or insufficient government funding and we may need to terminate our Medicare Advantage contracts with respect to unprofitable markets, which may have a material adverse effect on our financial position, results of operations or cash flows. In addition, as a result of the competitive bidding process, we may in the future be required to reduce benefits or charge our members an additional premium in order to maintain our current level of profitability, either of which could make our health plans less attractive to members and adversely affect our membership.

CMS's risk adjustment payment system and budget neutrality factors make our revenue and profitability difficult to predict and could result in material retroactive adjustments to our results of operations.

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, diagnosis data from ambulatory treatment settings, including hospital outpatient facilities and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. As part of the phase-in, during 2003, risk adjusted payments accounted for 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional CMS demographic rate books. The portion of risk

adjusted payments was increased to 30% in 2004, 50% in 2005 and 75% in 2006, and has increased to 100% in 2007. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare premium revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information, which has an impact on our risk scores.

Payments to Medicare Advantage plans are also adjusted by a "budget neutrality" factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The President's budget for 2005 assumed the phasing out of the budget neutrality adjustments over a five year period from 2007 through 2011. On December 21, 2005, the U.S. Senate passed legislation that reduces federal funding for Medicare Advantage plans by approximately $6.2 billion over five years. Among other changes, the legislation provides for an accelerated phase out of budget neutrality for risk adjustment of payments made to Medicare Advantage plans. The U.S. House of Representatives has passed similar legislation but must approve the final version of the Senate legislation before the legislation can go to the President for signature. These legislative changes may change payments to Medicare Advantage plans in general.

In addition, the Medicare Payment Advisory Commission (MedPac), an independent federal body established to advise Congress on issues concerning the Medicare program, in its report to Congress issued on March 1, 2007, has noted that in 2006 the federal government spent 12% more to provide coverage to Medicare beneficiaries who are covered through a private Medicare Advantage plan than through the traditional Medicare program. As a result, MedPac has recommended that Congress gradually lower rates paid to Medicare Advantage plans to ensure financial neutrality with the traditional Medicare program. A U.S. House of Representatives subcommittee is holding hearings to consider this issue. We cannot predict if, when or to what degree Congress may act on the MedPac recommendation, but any reduction in the Medicare Advantage rates could have an adverse effect on our revenue, financial position, results of operations or cash flow.

If during the open enrollment season our Medicare Advantage members enroll in another Medicare Advantage plan, they will be automatically disenrolled from our plan, possibly without our immediate knowledge.

Pursuant to the MMA, members enrolled in one insurer's Medicare Advantage program will be automatically unenrolled from that program if they enroll in another insurer's Medicare Advantage program. If our members enroll in another insurer's Medicare Advantage program during the open enrollment season, we may not discover that such member has been unenrolled from our program until such time as we fail to receive reimbursement from the CMS in respect of such member, which may occur several months after the end of the open season. As a result, we may discover that a member has unenrolled from our program after we have already provided services to such individual. Our profitability would be reduced as a result of such failure to receive payment from CMS if we had made related payments to providers and were unable to recoup such payments from them.

We face intense competition to attract and retain employees and independent agents and brokers.

We are dependent on retaining existing employees, attracting and retaining additional qualified employees to meet current and future needs and achieving productivity gains. Our life insurance subsidiary, GA Life, has historically experienced a very high level of turnover in its home service agents, through which it places a majority of its premiums, and we expect this trend to continue. Our inability to retain existing employees or attract additional employees could have a material adverse effect on our business, financial condition and results of operations.

In addition, in order to market our products effectively, we must continue to recruit, retain and establish relationships with qualified independent agents and brokers. We may not be able to recruit, retain and establish relationships with agents and brokers. Independent agents and brokers are typically not exclusively dedicated to us and may frequently also market our competitors' managed care products. We face intense competition for the services and allegiance of independent agents and brokers. If such agents and brokers do not help us to maintain our current customer accounts or establish new accounts, our business and profitability could be adversely affected.

Our investment portfolios are subject to varying economic and market conditions.

We have exposure to market risk in our investment activities. The market values of our investments vary from time to time depending on economic and market conditions. Fixed maturity securities expose us to interest rate risk. Equity securities expose us to equity price risk. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. These and other

factors also affect the equity securities owned by us. The outlook of our investment portfolio depends on the future direction of interest rates, fluctuations in the equity securities market and in the amount of cash flows available for investment. For additional information, see "Management's Discussion and Analysis of Financial Condition and Results of Operations – Quantitative and Qualitative Disclosures About Market Risk" for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, real estate and equity investments, amonst others, which could generate higher returns on our investments. If we fail to comply with these laws and regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, we may be required to sell those investments.

The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.

Substantially all of our business activity is with insureds located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. For example, in April 2006 the government of Puerto Rico announced a possible lack of budgetary funds to complete the fiscal year ended June 30, 2006, which caused various rating agencies to downgrade the government's debt and led to a two-week government shutdown. In order to solve the lack of budgetary funds, the government approved certain fiscal and tax reforms in order to raise additional funds for future fiscal years. The Puerto Rico government, however, recently announced a possible lack of budgetary funds to complete the fiscal year ending June 30, 2007 of approximately $600 million. Although the Puerto Rico government has proposed certain measures to resolve this insufficiency, there can be no assurance that similar events will not occur in the future, which may adversely affect the economy of Puerto Rico.

A number of key economic indicators suggest that the Puerto Rico economy is suffering a slowdown, as a result of, among other things, the persistent high levels of oil prices, the current trend in short-term interest rates, the depreciation of the dollar (which affects the value of imports from foreign countries, which account for approximately 50% of total imports to Puerto Rico) and the deceleration of public investment due to the current fiscal situation in Puerto Rico.

If economic conditions in Puerto Rico deteriorate, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations.

We may not be able to retain our executive officers and significant employees, and the loss of any one or more of these officers and their expertise could adversely affect our business.

Our operations are highly dependent on the efforts of our senior executives, each of whom has been instrumental in developing our business strategy and forging our business relationships. While we believe that we could find replacements, the loss of the leadership, knowledge and experience of our executive officers could adversely affect our business. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the industries in which we operate have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. We do not currently maintain key-man life insurance on any of our executive officers.

The success of our business depends on developing and maintaining effective information systems.

Our business and operations may be harmed if we do not maintain our information systems and the integrity of our proprietary information. We are materially dependent on our information systems for all aspects of our business operations, including monitoring utilization and other factors, supporting our managed care management techniques, processing provider claims and providing data to our regulators, and our ability to compete depends on our ability to continue to adapt technology on a timely and cost-effective basis. Malfunctions in our information systems, communication and energy disruptions, security breaches or the failure to maintain effective and up-to-date information systems could disrupt our business operations, alienate customers, contribute to customer and provider

disputes, result in regulatory violations and possible liability, increase administrative expenses or lead to other adverse consequences. The use of patient data by all of our businesses is regulated at federal and local levels. These laws and rules change frequently and developments require adjustments or modifications to our technology infrastructure.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems and increases in administrative expenses. We recently completed a system conversion process related to our property and casualty insurance business. We started the implementation of this system in April 2005 and completed it on October 1, 2006 at an estimated cost of $4 million. In addition, we recently selected Quality Care Solutions, Inc. (QCSI) to assess and implement new core business applications for our managed care segment. We expect the assessment to be completed in 2007, at which point we plan to convert our managed care systems over time by line of business, with the first line of business expected to be converted in the first half of 2009. We expect the managed care conversion process to be completed by 2012 at a total cost of approximately $40 million. If we are unsuccessful in implementing these improvements in a timely manner or if these improvements do not meet our customers' requirements, we may not be able to recoup these costs and expenses and effectively compete in our industry.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other event or developments could result in compromises or breaches of our security system and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be adversely affected by cancellation of contracts and loss of members if they are not prevented.

We are required to evaluate our internal control over financial reporting under Section 404 of Sarbanes Oxley, and any adverse results from such evaluation could result in a loss of investor confidence in our financial reports and have an adverse effect on our stock price.

Pursuant to Section 404 of the Sarbanes-Oxley Act of 2002 (Sarbanes-Oxley), beginning with our Annual Report on Form 10-K for the fiscal year ending December 31, 2007, we will be required to furnish a report by our management on our internal control over financial reporting. Such a report will contain, among other matters, an assessment of the effectiveness of our internal control over financial reporting as of the end of our fiscal year, including a statement as to whether or not our internal control over financial reporting is effective. This assessment must include disclosure of any material weaknesses in our internal control over financial reporting identified by management.

The Committee of Sponsoring Organizations of the Treadway Commission (COSO) provides a framework for companies to assess and improve their internal control systems. The Public Company Accounting Oversight Board's Auditing Standard No. 2 provides the professional standards and related performance guidance for auditors to attest to, and report on, management's assessment of the effectiveness of internal control over financial reporting under Sarbanes-Oxley Section 404. Management's assessment of internal control over financial reporting requires management to make subjective judgments and some of the judgments will be in areas that may be open to

interpretation and therefore the report may be uniquely difficult to prepare. We are still performing the system and process documentation and evaluation needed to comply with Sarbanes-Oxley Section 404, which is both costly and challenging.

During this process, if our management identifies one or more material weaknesses in our internal control over financial reporting, we will be unable to assert such internal control is effective. If we are unable to assert that our internal control over financial reporting is effective as of December 31, 2007, or if our auditors are unable to attest that our management's report is fairly stated or they are unable to express an opinion on the effectiveness of our internal controls as of December 31, 2008, we could lose investor confidence in the accuracy and completeness of our financial reports.

We cannot be certain as to the timing of completion of our evaluation, testing and any required remediation. If we are not able to complete our assessment under Sarbanes-Oxley Section 404 in a timely manner, we would be unable to conclude that our internal control over financial reporting is effective as of December 31, 2007.

We face risks related to litigation.

We are, or may be in the future, a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we may be subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include:

- claims relating to the denial of managed care benefits;
- medical malpractice actions;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts;
- disputes related to self-funded business;
- disputes over co-payment calculations;
- claims related to the failure to disclose certain business practices;
- claims relating to customer audits and contract performance; and
- claims by regulatory agencies or whistleblowers for regulatory non-compliance, including but not limited to fraud.

We are a defendant in various lawsuits, including a class action, some of which involve claims for substantial and/or indeterminate amounts and the outcome of which is unpredictable. While we are defending these suits vigorously, we will incur expenses in the defense of these suits. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition. See "Business — Legal Proceedings."

Large-scale natural disasters may have a material adverse effect on our business, financial condition and results of operations.

Puerto Rico has historically been at a relatively high risk of natural disasters such as hurricanes and earthquakes. If Puerto Rico were to experience a large-scale natural disaster, claims incurred by our property and casualty insurance segment would likely increase and our properties may incur substantial damage, which could have a material adverse

effect on our business, financial condition and results of operations.

Covenants in our credit agreements and note purchase agreements may restrict our operations.

We are a party to two secured loans with a commercial bank in an aggregate amount of $61.0 million, of which we had a total outstanding balance of $27.6 million and $10.5 million, respectively, as of December 31, 2006. Also, we have an aggregate of $145.0 million of senior unsecured notes, consisting of $50.0 million aggregate principal amount of 6.30% notes due 2019, $60.0 million aggregate principal amount of 6.60% notes due 2020 and $35.0

million aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The credit agreements and the note purchase agreements governing the notes contain covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These covenants could restrict our operations. In addition, if we fail to make any required payment under our credit agreements or note purchase agreements governing the notes or to comply with any of the covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our credit agreements or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the credit agreements, cease to make further extensions of credit. If the indebtedness under our credit agreements or note purchase agreements is accelerated, we may be unable to repay or finance the amounts due and our business may be materially adversely affected.

We may incur additional indebtedness in the future. Covenants related to such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

We may incur additional indebtedness in the future. Our debt service obligations may require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be prohibited by applicable regulatory requirements or unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreements and note purchase agreements and the acceleration of amounts due thereunder. Indebtedness could also limit our ability to pursue desirable business opportunities, and may affect our ability to maintain an investment grade rating for our indebtedness.

We expect to pursue acquisitions in the future.

We may acquire additional companies if consistent with our strategic plan for growth. The following are some of the risks associated with acquisitions that could have a material adverse effect on our business, financial condition and results of operations:

- disruption of on-going business operations, distraction of management, diversion of resources and difficulty in maintaining current business standards, controls and procedures;
- difficulty in integrating information technology of acquired entity and unanticipated expenses related to such integration;
- difficulty in the integration of the new company's accounting, financial reporting, management, information, human resources and other administrative systems and the lack of control if such integration is delayed or not implemented;
- difficulty in the implementation of controls, procedures and policies appropriate for filers with the Securities and Exchange Commission at companies that prior to acquisition lacked such controls, policies and procedures;
- potential unknown liabilities associated with the acquired company;
- failure of acquired businesses to achieve anticipated revenues, earnings or cash flow;

- dilutive issuances of equity securities and incurrence of additional debt to finance acquisitions;
- other acquisition-related expenses, including amortization of intangible assets and write-offs; and
- competition with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

In addition, we may not successfully realize the intended benefits of any acquisition or investment.

Risks Relating to Taxation

If the Company is considered to be a controlled foreign corporation under the related person insurance income rules for U.S. federal income tax purposes, U.S. persons that own the Company's Class B shares could be subject to adverse tax consequences.

The Company does not expect that it will be considered a controlled foreign corporation under the related person insurance income rules (a RPII CFC) for U.S. federal income tax purposes. However, because RPII CFC status depends in part upon the correlation between an insurance company's shareholders and such company's insurance customers and the extent of such company's insurance business outside its country of incorporation, there can be no assurance that the Company will not be a RPII CFC in any taxable year. The Company does not intend to monitor whether or not it generates RPII or becomes an RPII CFC. If the Company were a RPII CFC in any taxable year, certain adverse tax consequences could apply to U.S. persons that own the Company's Class B shares. Please read the section called "Certain United States Federal Income Tax Considerations—Related Person Insurance Income Rules."

If the Company is considered to be a passive foreign investment company for U.S. federal income tax purposes, U.S. persons that own the Company's Class B shares could be subject to adverse tax consequences.

The Company does not expect that it will be considered a "passive foreign investment company" (a PFIC) for U.S. federal income tax purposes. However, since PFIC status depends upon the composition of a company's income and assets and the market value of its assets (including, among others, less than 25 percent owned equity investments and the Company's ability to use the proceeds from this offering in a timely fashion) from time to time, there can be no assurance that the Company will not be considered a PFIC for any taxable year. The Company's belief that it is not a PFIC is based, in part, on the fact that the PFIC rules include provisions intended to provide an exception for bona fide insurance companies predominately engaged in an insurance business. However, the scope of this exception is not entirely clear and there are no administrative pronouncements, judicial decisions or Treasury regulations that provide guidance as to the application of the PFIC rules to insurance companies. If the Company were treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own the Company's Class B shares. Please read the section called "Certain United States Federal Income Tax Considerations—Passive Foreign Investment Company Rules."

Risks Relating to the Regulation of Our Industry

Changes in governmental regulations, or the application thereof, may adversely affect our business, financial condition and results of operations.

Our business is subject to changing Federal and local legal, legislative and regulatory environments, including general business regulations and laws relating to taxation, privacy, data protection and pricing. See "Regulation." In addition, our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. Some of the more significant proposed regulatory changes that may affect our business are:

- initiatives to increase healthcare regulation, including efforts to expand the tort liability of health plans;
- local government plans and initiatives, and
- Medicare and Reform reform legislation.

The U.S. Congress is developing legislation aimed at patient protection, including proposed laws that could expose insurance companies to damages, and in some cases punitive damages, for certain coverage determinations including the denial of benefits or delay in providing benefits to members. Similar legislation has been proposed in Puerto Rico. A U.S. House of Representatives subcommittee is also considering a MedPac recommendation to lower Medicare Advantage rates to ensure financial neutrality with the traditional Medicare program.

Regulations imposed by the Commissioner of Insurance, among other things, influence how our insurance subsidiaries conduct business and how we and they solicit subscriptions for shares of capital stock, and place limitations on investments and dividends. Possible penalties for violations of such regulations include fines, orders to cease or change practices or behavior and possible suspension or termination of licenses. The regulatory powers of the Commissioner of Insurance are designed to protect policyholders, not shareholders. While we cannot predict the terms of future regulation, the enactment of new legislation could affect the cost or demand of insurance policies, limit our ability to obtain rate increases in those cases where rates are regulated, otherwise restrict our operations, limit the expansion of our business, limit our ability to issue shares of common stock, expose us to expanded liability or impose additional compliance requirements. In addition, we may incur additional operating expenses in order to comply with new legislation and may be required to revise the ways in which we conduct our business.

Future regulatory actions by the Commissioner of Insurance or other governmental agencies could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations.

If we are deemed to have violated the insurance company change of control provisions in Puerto Rico insurance laws, we may suffer adverse consequences.

We are subject to change of control statutes applicable to insurance companies. These statutes regulate, among other things, the acquisition of control of an insurance company or a holding company of an insurance company. Under these statutes, no person may make an offer to acquire or to sell the issued and outstanding voting stock of an insurance company, which constitutes 10% or more of the issued and outstanding stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, or solicit or receive funds in exchange for the issuance of new shares of our or our insurance subsidiaries' capital stock, without the prior approval of the Commissioner of Insurance. Our amended and restated articles of incorporation (the articles) prohibit any institutional investor from owning 10% or more of our voting power and any person that is not an institutional investor from owning 5% or more of our voting power. We cannot, however, assure you that ownership of our securities will remain below these thresholds. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles. If the Commissioner of Insurance determines that a change of control has occurred, we could be subject to fines and penalties, and in some instances the Commissioner of Insurance would have the discretion to revoke our operating licenses.

We are also subject to change of control limitations pursuant to our BCBSA license agreements. The BCBSA ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for an institutional investor and less than 5% for a noninstitutional investor, both as defined in our articles. In addition, no person may beneficially own shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest, whether voting or non-voting, in our company. This provision in our articles cannot be changed without the prior approval of the BCBSA and the vote of holders of at least 75% of our common stock. See "Description of Capital Stock."

Our insurance subsidiaries are subject to minimum capital requirements. Our failure to meet these standards could subject us to regulatory actions.

Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by our insurance subsidiaries to us. Although we are currently in compliance with these requirements, there can be no assurance that we will continue to comply in the future. Failure to maintain required levels of capital

or to otherwise comply with the reporting requirements of the Commissioner of Insurance could subject our insurance subsidiaries to corrective action, including government supervision or liquidation, or require us to provide financial assistance, either through subordinated loans or capital infusions, to our subsidiaries to ensure they maintain their minimum statutory capital requirements.

We are also subject to minimum capital requirements pursuant to our BCBSA license agreements. See "—The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations."

We are required to comply with laws governing the transmission, security and privacy of health information.

Certain implementing regulations of HIPAA require us to comply with standards regarding the formats for electronic transmission, and the privacy and security of certain health information within our company and with third parties, such as managed care providers, business associates and our members. These rules also provide access rights and other rights for health plan beneficiaries with respect to their health information. These regulations include standards for certain electronic transactions, including encounter and claims information, health plan eligibility and payment information. Compliance with HIPAA is enforced by the Department of Health and Human Service's Office for Civil Rights for privacy, CMS for security and electronic transactions, and by the Department of Justice for criminal violations. Further, the Gramm-Leach-Bliley Act imposes certain privacy and security requirements on insurers that may apply to certain aspects of our business as well.

We continue to implement and revise our health information policies and procedures to monitor and ensure our compliance with these laws and regulations. Furthermore, Puerto Rico's ability to promulgate its own laws and regulations (including those issued in response to the Gramm-Leach-Bliley Act), such as Act No. 194 of August 25, 2000, also known as the Patient's Rights and Responsibilities Act, including those more stringent than HIPAA, and uncertainty regarding many aspects of such state requirements, make compliance with applicable health information laws more difficult. For these reasons, our total compliance costs may increase in the future.

Risks Relating to this Offering

There has been no prior public market for our common stock, and we cannot assure you that an active trading market in our stock will develop or be sustained.

Prior to this offering, there has been no public market for our common stock. We cannot assure you that an active trading market in our Class B common stock will develop or be sustained after this offering. Although we intend to apply to list our Class B common stock on the New York Stock Exchange, we do not know whether investors will find our Class B common stock to be an attractive investment or whether firms will be interested in making a market for our stock. Consequently, you may not be able to resell your shares above the initial public offering price and may suffer a loss on your investment.

You will incur immediate and substantial dilution in the net tangible book value of the Class B common stock you purchase in this offering.

Purchasers of Class B common stock in this offering will suffer an immediate and substantial dilution in net tangible book value per share. Dilution is the amount by which the offering price per share paid by the purchasers of Class B common stock will exceed the net tangible book value per share of common stock after the offering. After giving effect to the sale by us of shares of Class B common stock at an assumed initial public offering price of $ per share, the mid-point of the range shown on the cover of this prospectus, and our payment of estimated underwriting discounts and commissions and estimated offering expenses, our net tangible book value as of December 31, 2006 would have been $ million, or $ per share of common stock. This represents an immediate increase in net tangible book value to existing shareholders of $ per Class A share and an immediate dilution to new investors of $ per Class B share. For a more detailed description of these matters, see "Dilution."

Future sales of our Class B common stock, or the perception that such future sales may occur, may have an adverse impact on its market price.

Sales of a substantial number of shares of our common stock in the public market following this offering, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limit our future ability to raise capital through an offering of equity securities. After completion of this offering, there will be shares of Class B common stock and shares of Class A common stock issued and

outstanding, or shares of Class B common stock and shares of Class A common stock if the underwriters exercise their over-allotment option in full. Approximately % of our Class A common stock will be subject to contractual lockup restrictions for one year following our initial public offering. Thereafter, such shares will become freely tradable without restriction or further registration under the Securities Act by persons other than our "affiliates" within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the New York Stock Exchange (NYSE) and will not be fungible with our listed Class B shares. In addition, one year after our initial public offering, our board of directors may, at its discretion, cause approximately half of our Class A shares to be converted to Class B shares in connection with an underwritten public secondary offering. On the fifth anniversary of this initial public offering, [or such earlier date after the one-year anniversary of the initial public offering as all claims with respect to which anti-dilution protections are afforded to Class B shares have been resolved], all of our Class A shares may at the discretion of our board of directors be converted to Class B shares. For a description of shares eligible for sale in the public market, see "Shares Eligible for Future Sale."

The initial public offering price of our Class B common stock may not be indicative of the market price of our Class B common stock after this offering and our stock price could be highly volatile.

The initial public offering price of our Class B common stock is based on numerous factors and may not be indicative of the market price of our Class B common stock after this offering. These factors include:

- variations in actual or anticipated operating results;
- changes in or failure to meet earnings estimates of securities analysts;
- market conditions in the managed care industry;
- regulatory actions and general economic and stock market conditions; and
- the availability for sale, or sales, of a significant number of shares of our Class B common stock in the public market.

These and other factors may have a significant effect on the market price of our Class B common stock after this offering. Accordingly, the market price of our Class B common stock may decline below the initial public offering price.

Puerto Rico insurance laws and regulations and provisions of our articles and bylaws could delay, deter or prevent a takeover attempt that shareholders might consider to be in their best interests and may make it more difficult to replace members of our board of directors and have the effect of entrenching management.

Puerto Rico insurance laws and the regulations promulgated thereunder, and our articles and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

Our license agreements with the BCBSA require that our articles contain certain provisions, including ownership limitations. See "—If we are deemed to have violated the insurance company change of control provisions in Puerto Rico insurance laws, we may suffer adverse consequences."

Other provisions included in our articles and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. In particular, our articles and bylaws:

- permit our board of directors to issue one or more series of preferred stock;
- divide our board of directors into three classes serving staggered three-year terms;

- limit the ability of shareholders to remove directors;
- impose restrictions on shareholders' ability to fill vacancies on our board of directors;
- impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and
- impose restrictions on shareholders' ability to amend our articles and bylaws.

See also "—If we are deemed to have violated the insurance company change of control provisions in Puerto Rico insurance laws, we may suffer adverse consequences."

Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance may also delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, the Commissioner of Insurance must review any merger, consolidation or new issue of shares of capital stock of an insurer or its parent company and make a determination as to the fairness of the transaction. Also, a director of an insurer must meet certain requirements imposed by Puerto Rico insurance laws.

These voting and other restrictions may operate to make it more difficult to replace members of our board of directors and may have the effect of entrenching management regardless of their performance.

SPECIAL NOTE REGARDING FORWARD-LOOKING STATEMENTS

This prospectus contains forward-looking statements, as such term is defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that include information about possible or assumed future sales, results of operations, developments, regulatory approvals or other circumstances and may be found in the sections of this prospectus entitled “Risk Factors”, “Business—Company Overview”, “—Industry Overview”, and “—Our St “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and elsewhere in this prospectus. Statements that use the terms “believe”, “expect”, “plan”, “intend”, “estimate”, “anticipate”, “project”, “may”, “ “should” and similar expressions, whether in the positive or negative, are intended to identify forward-looking statements.

All forward-looking statements in this prospectus reflect our current views about future events and are based on assumptions and subject to risks and uncertainties. Consequently, actual results may differ materially from those anticipated in these forward-looking statements as a result of various factors, including all the risks discussed in “Risk Factors” and elsewhere in this prospectus.

In addition, we operate in a highly competitive, constantly changing environment that is significantly influenced by very large organizations that have resulted from business combinations, aggressive marketing and pricing practices of competitors and regulatory oversight. The following is a summary of factors, the results of which, either individually or in combination, if markedly different from our planning assumptions, could cause our results to differ materially from those expressed in any forward-looking statements contained in this prospectus:

- trends in health care costs and utilization rates;
- ability to secure sufficient premium rate increases;
- competitor pricing below market trends of increasing costs;
- re-estimates of our policy and contract liabilities;
- changes in government regulation of managed care, life insurance or property and casualty insurance;
- significant acquisitions or divestitures by major competitors;
- introduction and use of new prescription drugs and technologies;
- a downgrade in our financial strength ratings;
- litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;
- ability to contract with providers consistent with past practice;
- ability to successfully implement our disease management and utilization management programs;
- volatility in the securities markets and investment losses and defaults;
- general economic downturns, major disasters, and epidemics.

The foregoing list should not be construed to be exhaustive. We believe the forward-looking statements in this prospectus are reasonable; however, there is no assurance that the actions, events or results anticipated by the forward-looking statements will occur or, if any of them do, what impact they will have on our results of operations or financial condition. In view of these uncertainties, you should not place undue reliance on any forward-looking statements, which are based on our current expectations. Further, forward-looking statements speak only as of the date they are made, and, other than as required by applicable law, including the securities laws of the United States, we do not intend to update or revise any of them in light of new information or future events.

USE OF PROCEEDS

We estimate that our proceeds from this offering, after deducting underwriting discounts and commissions and estimated offering expenses payable by us, will be approximately $ million, assuming the Class B shares are offered at $ per share, which is the midpoint of the estimated initial public offering price range set forth on the cover page of this prospectus (or approximately $ million if the underwriters fully exercise their over-allotment option). A $1.00 increase or decrease in the assumed initial public offering price per share would increase or decrease the net proceeds to us by approximately $ million. We will not receive any proceeds from the sale of shares by the selling shareholders.

We intend to use the net proceeds from this offering to repay a portion of our outstanding indebtedness and for general corporate purposes, including working capital and possible acquisitions and investments.

We intend to repay a secured loan payable due on July 1, 2024, with interest payable at 100 basis points over LIBOR, which as of December 31, 2006 had a balance of $27.6 million and an interest rate of 6.35%.

The amounts described above reflect our estimate of the use of our net proceeds from this offering, based on our current plans. Management will have significant flexibility in applying the net proceeds from this offering. Pending any use, the net proceeds of this offering will be invested in short-term, interest-bearing investment-grade securities.

DIVIDEND POLICY

Subject to the limitations under Puerto Rico corporation law and any preferential dividend rights of outstanding preferred stock, of which there is currently none outstanding, holders of common stock are entitled to receive their pro rata share of such dividends or other distributions as may be declared by our board of directors out of funds legally available therefor.

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. We are required to maintain minimum capital of $1.0 million for our managed care subsidiary, $2.5 million for our life insurance subsidiary and $3.0 million for our property and casualty insurance subsidiary. In addition, our credit agreements restrict our ability to pay dividends if a default thereunder has occurred and is continuing.

In March 2007, we declared and paid dividends amounting to approximately $2.5 million. In January 2006 we declared and paid dividends amounting to $6.2 million. We did not declare any dividends in prior years. Prior to December 31, 2002, our managed care subsidiary was prohibited under its tax exemption ruling from declaring dividends. See “Business.”

We do not expect to pay any cash dividends for the foreseeable future. We currently intend to retain future earnings, if any, to finance operations and expand our business. The ultimate decision to pay a dividend, however, remains within the discretion of our board of directors and may be affected by various factors, including our earnings, financial condition, capital requirements, level of indebtedness, statutory and contractual limitations and other considerations our board of directors deems relevant.

CAPITALIZATION

The following table sets forth our cash and capitalization as of December 31, 2006, on an actual and as adjusted basis to reflect the issuance and sale by us of shares of Class B common stock in this offering at an assumed initial public offering price of $ per share, which is the mid-point of the offering price range set forth on the cover page of this prospectus, and our payment of estimated underwriting discounts and commissions and our estimated offering expenses.

The following table should be read in conjunction with the information under "Use of Proceeds", "Selected Consolidated Financial and Additional Data" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our consolidated financial statements and related notes thereto included in this prospectus.

	December 31, 2006	
	Adjusted[1]	Adjusted for IPO[1][2]
	(in millions, except per share data)	
Cash and cash equivalents	$ 81.3	$
Long-term debt, including current portion	$ 183.1	$
Shareholders' equity:		
Preferred stock, par value $1.00 per share, 100,000,000 shares authorized, none issued and outstanding [1]	—	
Common stock, par value $1.00 per share, 100,000,000 shares authorized; 26,733,000 shares issued and outstanding (actual) [1]	26.7	
Additional paid-in capital [1]	124.0	
Retained earnings	211.3	
Accumulated other comprehensive loss	(19.4)	
Total shareholders' equity	342.6	—
Total capitalization	$ 525.7	$

(1) Reflects the change in par value and authorized shares established in our Amended and Restated Articles, which became effective on February 21, 2007, and the 3,000 for one split of our shares of common stock to be effected by us on May 1, 2007.

(2) A $1.00 increase or decrease in the assumed initial public offering price per share would increase or decrease each of cash, shareholders' equity and total capitalization by , assuming the number of shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the estimated underwriting discounts and estimated offering expenses payable by us.

DILUTION

If you invest in our Class B common stock, your interest will be diluted to the extent of the difference between the public offering price per share of our Class B common stock and the as adjusted net tangible book value per share of our common stock after this offering. Dilution results from the fact that the per share offering price of the Class B common stock is in excess of the book value per share attributable to our existing shareholders for the presently outstanding common stock.

Our net tangible book value as of December 31, 2006 was approximately $342.6 million, or $38,447 per share of our common stock (or $12.82 per share after giving effect to the 3,000-for-one stock split to be effected by us on May 1, 2007). Net tangible book value per share is determined by dividing our tangible shareholders' equity, which is total tangible assets less total liabilities, by the aggregate number of shares of common stock outstanding. Tangible assets represent total assets excluding goodwill and other intangible assets.

After giving effect to our sale of shares of Class B common stock in this offering at an assumed offering price of $ per share (the midpoint of the estimated price range shown on the cover page of this prospectus), and the application of the proceeds from this offering as described under "Use of Proceeds", as adjusted net tangible book value (deficiency) as of December 31, 2006 would have been $ million, or $ per share of common stock. This represents an immediate increase in as adjusted net tangible book value of $ per share to our existing shareholders and an immediate dilution of $ per share to new investors purchasing shares of Class B common stock in this offering. The following table illustrates this dilution per share to new investors:

Assumed initial public offering price per share of Class B common stock		$
Net tangible book value per share as of December 31, 2006	$	
Increase per share attributable to new investors		
As adjusted net tangible book value (deficit) per share after the offering		
Dilution per share of Class B common stock		
		$

A $1.00 increase (decrease) in the assumed initial public offering price of $ per Class B share would increase (decrease) our as adjusted net tangible book value per share of common stock after this offering by $, and would increase (decrease) the dilution to new investors by $, assuming the number of Class B shares offered by us, as set forth on the cover page of this prospectus, remains the same and after deducting the estimated underwriting discounts and estimated offering expenses payable by us.

The following table summarizes, as of December 31, 2006, the number of shares of common stock purchased from us, the total consideration paid to us and the average price per share paid by our existing shareholders and to be paid by new investors purchasing shares of common stock from us in this offering, before deducting the underwriting discount and estimated offering expenses payable by us.

	Shares Purchased		**Total Consideration**		
	Number	**Percent**	**Amount**	**Percent**	**Average Price per Share**
Existing shareholders (Class A)		%	$	%	$
New investors (Class B)					
Total		100.0%	$	100.0%	$

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SELECTED CONSOLIDATED FINANCIAL AND ADDITIONAL DATA

The table below provides selected consolidated financial and additional statistical data for each of the five years in the period ended December 31, 2006. We derived the statement of earnings data for the five years in the period ended December 31, 2006, and the balance sheet data as of December 31, 2006, 2005, 2004, 2003 and 2002, from our audited consolidated financial statements.

You should read this selected consolidated financial data together with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and our audited consolidated financial statements and accompanying notes included elsewhere in this prospectus.

Until October 31, 2006, we had contracts with the government of Puerto Rico to be the Reform insurance carrier for three of the eight geographical areas into which Puerto Rico is divided for purposes of the Reform. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. The contracts for the other two regions were renewed for additional one-year periods. The premiums earned, net and operating income related to the operations of the Metro-North region during the year ended December 31, 2006 amounted to $161.6 million and $5.4 million, respectively, and during the year ended December 31, 2005 amounted to $200.9 million and $3.5 million, respectively.

	Year ended December 31,				
(Dollars in millions, except per share data)	**2006[1]**	**2005**	**2004**	**2003**	**2002**
Statement of Earnings Data					
Revenues:					
Premiums earned, net	$ 1,511.6	$ 1,380.2	$ 1,299.0	$ 1,264.4	$ 1,236.6
Administrative service fees	14.1	14.4	9.2	8.3	9.5
Net investment income	42.7	29.1	26.8	24.7	24.8
Total operating revenues	1,568.4	1,423.7	1,335.0	1,297.4	1,270.9
Net realized investment gains	0.8	7.2	11.0	8.4	0.2
Net unrealized investment gain (loss) on trading securities	7.7	(4.7)	3.0	14.9	(8.3)
Other income, net	2.3	3.7	3.4	4.7	2.1
Total revenues	1,579.2	1,429.9	1,352.4	1,325.4	1,264.9
Benefits and expenses:					
Claims incurred	1,259.0	1,208.3	1,115.8	1,065.4	1,062.0
Operating expenses	236.1	181.7	171.9	165.1	148.5
Total operating costs	1,495.1	1,390.0	1,287.7	1,230.5	1,210.5
Interest expense	16.6	7.6	4.6	3.2	3.6
Total benefits and expenses	1,511.7	1,397.6	1,292.3	1,233.7	1,214.1
Income before taxes	67.5	32.3	60.1	91.6	50.8
Income tax expense	13.0	3.9	14.3	65.4	2.6
Net income	$ 54.5	$ 28.4	$ 45.8	$ 26.2	$ 48.2
Weighted average number of shares outstanding	8,911	8,904	8,919	9,180	9,531
Weighted average number of shares outstanding giving	26,733,000	26,712,000	26,757,000	27,540,000	28,593,000

effect to 3,000-for-one stock split					
Basic net income per share	$ 6,120	$ 3,193	$ 5,135	$ 2,857	$ 1,085
Basic net income per share giving effect to 3,000-for-one stock split	$ 2.04	$ 1.06	$ 1.71	$ 0.95	$ 1.69

(Dollars in millions, except per share data)	As of December 31, 2006 (1)	2005	2004	2003	2002
Balance Sheet Data					
Cash and cash equivalents	$ 81.3	$ 49.0	$ 35.1	$ 47.7	$ 82.8
Total assets	1,345.5	1,137.5	919.7	834.6	721.9
Long-term borrowings	183.1	150.6	95.7	48.4	50.0
Total shareholders' equity	342.6	308.7	301.4	254.3	231.7

	Year ended December 31, 2006	2005	2004	2003	2002
Additional Managed Care Data (2)					
Medical loss ratio	87.6%	90.3%	88.3%	86.6%	87.7%
Operating expense ratio	11.5%	10.8%	10.8%	10.8%	10.4%
Medical membership (period-end)	979,506	1,252,649	1,236,108	1,235,349	1,273,256

(1) On January 31, 2006, we completed the acquisition of GA Life. The results of operations and financial condition of GA Life are included in this table for the period following the effective date of the acquisition. See note 3 to the audited consolidated financial statements included elsewhere herein.

(2) Does not reflect inter-segment eliminations.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Overview

We are the largest managed care company in Puerto Rico in terms of membership, with over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Reform, Medicare Advantage and Part D stand-alone PDP markets. The Reform is a Puerto Rico government-funded managed care program for the medically indigent, similar to the Medicaid program in the U.S. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico, serve approximately one million members across all regions of Puerto Rico and hold a leading market position covering approximately 25% of the population. For the year ended December 31, 2006, our managed care segment represented approximately 88.6% of our total consolidated premiums earned, net and approximately 62.1% of our operating income. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment has a market share of approximately 25% (in terms of premiums written) as of December 31, 2005. Our property and casualty segment has a market share of approximately 8.5% (in terms of direct premiums) as of December 31, 2006.

We participate in the managed care market through our subsidiary, TSI. Our managed care subsidiary is a BCBSA licensee, which provides us with exclusive use of the Blue Shield brand in Puerto Rico. We offer products to the commercial, Reform, Medicare Advantage and PDP market sectors, including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement.

We participate in the life insurance market through our subsidiary, GA Life (which resulted from the merger of our former subsidiary Seguros de Vida Triple-S, Inc. (SVTS) into GA Life) and in the property and casualty insurance market through our subsidiary, STS, which represented approximately 5.7% and 5.9%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2006 and 15.3% and 15.3%, respectively, of our operating income for that period.

The Commissioner of Insurance recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Puerto Rico insurance laws and for determining whether its financial condition warrants the payment of a dividend to its shareholders. No consideration is given by the Commissioner of Insurance to financial statements prepared in accordance with U.S. GAAP in making such determinations. See note 24 to our audited consolidated financial statements.

Intersegment revenues and expenses are reported on a gross basis in each of the operating segments but eliminated in the consolidated results. Except as otherwise indicated, the numbers presented in this prospectus do not reflect intersegment eliminations. These intersegment revenues and expenses affect the amounts reported on the financial statement line items for each segment, but are eliminated in consolidation and do not change net income. The following table shows premiums earned, net and net fee revenue and operating income for each segment, as well as the intersegment premiums earned, service revenues and other intersegment transactions, which are eliminated in the consolidated results:

	Year ended December 31,		
(Dollar amounts in millions)	**2006**	**2005**	**2004**
Premiums earned, net			

Managed care	$ 1,339.8	$ 1,279.5	$ 1,199.2
Life insurance	86.9	17.1	16.4
Property and casualty insurance	88.5	86.8	86.2
Intersegment premiums earned	(3.6)	(3.2)	(2.8)
Consolidated premiums earned, net	$ 1,511.6	$ 1,380.2	$ 1,299.0

(Dollar amounts in millions)	Year ended December 31, 2006	2005	2004
Administrative service fees			
Managed care	$ 16.9	$ 15.5	$ 10.3
Intersegment administrative service fees	(2.8)	(1.1)	(1.1)
Consolidated administrative service fees	$ 14.1	$ 14.4	$ 9.2

(Dollar amounts in millions)	Year ended December 31, 2006	2005	2004
Operating income			
Managed care	$ 45.5	$ 16.1	$ 36.2
Life insurance	11.2	3.0	0.6
Property and casualty insurance	11.2	12.3	7.7
Other segments and intersegment eliminations	5.4	2.3	2.8
Consolidated operating income	$ 73.3	$ 33.7	$ 47.3

Effective January 31, 2006, we completed the acquisition of 100% of the common stock of GA Life for $37.5 million, and effective June 30, 2006, we merged the operations of our life insurance subsidiary, SVTS, into GA Life. GA Life's results of operations and financial condition are included in our consolidated financial statements for the period following January 31, 2006. Our historical results of operations and "comparable basis" information for 2005 are included in this prospectus. Comparable basis information was determined by adding the historical statements of earnings for GA Life from February 1, 2005 to December 31, 2005 to our statements of earnings for 2005. Comparable basis information is presented in order to provide a more meaningful comparison of the 2006 and 2005 periods. Comparable basis information is not calculated in accordance with U.S. GAAP and is not intended to represent or be indicative of the results of operations that would have been reported by us had the acquisition been completed as of January 31, 2005. In addition, comparable basis information does not adjust for the inclusion in our 2006 results of results of our coinsurance funds withheld agreement with GA Life during January of that year. (See the unaudited pro forma combined financial statements included in note 3 to our consolidated financial statements included elsewhere in this prospectus.)

During the reported periods, we had one-year contracts with the government of Puerto Rico to be the Reform insurance carrier for three of the eight geographical areas into which Puerto Rico is divided for purposes of the Reform. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company, effective November 1, 2006. The contracts for the other two regions were renewed for an additional one-year period. The premiums earned, net related to the operations of the Metro-North region during the years 2006, 2005 and 2004 amounted to $161.6 million, $200.9 million and $184.7 million, respectively. The operating income of this region during the years 2006, 2005 and 2004 amounted to $5.4 million, $3.5 million and $4.4 million, respectively.

Results of Operations

Revenue

General. Our revenue consists primarily of (i) premium revenue we generate from our managed care business, (ii) administrative service fees we receive for administrative services provided to self-insured (ASO) employers, (iii) premiums we generate from our life insurance and property and casualty insurance businesses and (iv) investment income.

Managed Care Premium Revenue. Our revenue primarily consists of premiums earned from the sale of managed care products to the commercial market sector, including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement, as well as to the Medicare Advantage, Reform and PDP sectors. We receive a monthly payment from or on behalf of each member enrolled in our commercial managed care plans (excluding ASO). We recognize all premium revenue in our managed care

business during the month in which we are obligated to provide services to an enrolled member. Premiums we receive in advance of that date are recorded as unearned premiums.

Premiums are generally fixed by contract in advance of the period during which healthcare is covered. Our commercial premiums are generally fixed for the plan year in the annual renewal process. Our Medicare Advantage contracts entitle us to premium payments from CMS on behalf of each Medicare beneficiary enrolled in our plans, generally on a per member per month (PMPM) basis. We submit rate proposals to CMS in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the new competitive bidding process under the MMA. Retroactive rate adjustments are made periodically with respect to our Medicare Advantage plans based on the aggregate health status and risk scores of our plan participants.

Premium payments from CMS in respect of our Medicare Part D prescription drug plans are based on written bids submitted by us which include the estimated costs of providing the prescription drug benefits.

Administrative Service Fees. Administrative service fees include amounts paid to us for administrative services provided to self-insured employers. We provide a range of customer services pursuant to our ASO contracts, including claims administration, billing, access to our provider networks and membership services. Administrative service fees are recognized in the month in which services are provided.

Other Premium Revenue. Other premium revenue includes premiums generated from the sale of life insurance and property and casualty insurance products. Premiums on life insurance policies are billed in the month prior to the effective date of the policy, with a one-month grace period, and the related revenue is recorded as earned during the coverage period. If the insured fails to pay within the one-month grace period, we may cancel the policy. We recognize premiums on property and casualty contracts as earned on a pro rata basis over the policy term. Property and casualty policies are subscribed through general agencies, which bill policy premiums to their clients in advance or, in the case of new business, at the inception date and remit collections to us, net of commissions. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheet as unearned premiums and is transferred to premium revenue as earned.

Investment Income and Other Income. Investment income consists of interest income and other income consists of net realized gains on investment securities. See note 2(c) to our audited consolidated financial statements.

Expenses

Claims Incurred. Our largest expense is medical claims incurred, or the cost of medical services we arrange for our members. Medical claims incurred include the payment of benefits and losses, mostly to physicians, hospitals and other service providers, and to policyholders. We generally pay our providers on one of three bases: (1) fee-for-service contracts based on negotiated fee schedules; (2) capitated arrangements, generally on a fixed PMPM payment basis, whereby the provider generally assumes some of the medical expense risk; and (3) risk-sharing arrangements, whereby we advance a capitated PMPM amount and share the risk of the medical costs of our members with the provider based on actual experience as measured against pre-determined sharing ratios. Claims incurred also include claims incurred in our life insurance and property and casualty insurance businesses. Each segment's results of operations depend in significant part on our ability to accurately predict and effectively manage claims. A portion of the claims incurred for each period consists of claims reported but not paid during the period, as well as a management and actuarial estimate of claims incurred but not reported during the period.

The medical loss ratio (MLR), which is calculated by dividing managed care claims incurred by managed care premiums earned, net is one of our primary management tools for measuring these costs and their impact on our profitability. The medical loss ratio is affected by the cost and utilization of services. The cost of services is affected

by many factors, in particular our ability to negotiate competitive rates with our providers. The cost of services is also influenced by inflation and new medical discoveries, including new prescription drugs, therapies and diagnostic procedures. Utilization rates, which reflect the extent to which beneficiaries utilize healthcare services, significantly influence our medical costs. The level of utilization of services depends in large part on the age, health and lifestyle of our members, among other factors. As the medical loss ratio is the ratio of claims incurred to premiums earned, net it is affected not only by our ability to contain cost trends but also by our ability to increase

premium rates to levels consistent with or above medical cost trends. We use medical loss ratios both to monitor our management of healthcare costs and to make various business decisions, including what plans or benefits to offer and our selection of healthcare providers.

Operating Expenses. Operating expenses include commissions to external brokers, general and administrative expenses, cost containment expenses such as case and disease management programs, and depreciation and amortization. The operating expense ratio is calculated by dividing operating expenses by premiums earned, net and administrative service fees. A significant portion of our operating expenses are fixed costs. Accordingly, it is important that we maintain or increase our volume of business in order to distribute our fixed costs over a larger membership base. Significant changes in our volume of business will affect our operating expense ratio and results of operations. We also have variable costs, which vary in proportion to changes in volume of business. Our operating expense ratio has remained broadly constant over the past three years, notwithstanding membership growth, because of certain significant expenses incurred in recent years, including the costs associated with Sarbanes-Oxley Section 404 compliance, HIPAA compliance, additional legal expenses and related accruals in connection with certain litigation, costs associated with the acquisition of GA Life and consulting costs incurred in connection with information technology (IT) systems upgrades. We do not expect our operating expense ratios to decline in the near term, however, because we expect to incur material expenses in connection with the introduction of our new IT platform.

Membership

Our results of operation depend in large part on our ability to maintain or grow our membership. In addition to driving revenues, membership growth is necessary to successfully introduce new products, maintain an extensive network of providers and achieve economies of scale. Our ability to maintain or grow our membership is affected principally by the competitive environment and general market conditions.

In recent years, we have experienced a decrease in our fully insured commercial membership due to the highly aggressive pricing of our competitors, which has also affected our ability to increase premiums, and the shifting of Medicare eligibles from our Medicare complementary program and Reform program to Medicare Advantage plans offered by our competitors and, to a lesser extent, ourselves.

We believe that the Medicare Advantage and PDP programs provide a significant opportunity for growth in membership. We commenced offering Medicare Advantage products in 2005, with the introduction of our *Medicare Selecto* and *Medicare Optimo* plans. Membership in our Medicare Advantage programs increased by 126% in 2006; from 11,993 as of December 31, 2005 to 27,078 members as of December 31, 2006. In January 2006, we launched our stand-alone PDP plan, *FarmaMed*, which as of December 31, 2006, had 14,063 members. We expect that Medicare Advantage enrollment will continue to experience significant growth, but at a substantially slower pace than in this initial period.

The following table sets forth selected membership data as of the dates set forth below:

	As of December 31,		
	2006	**2005**	**2004**
Commercial [(1)]	580,850	612,218	621,665
Reform [(2)]	357,515	628,438	614,443
Medicare Advantage	27,078	11,993	-
Part D Stand-Alone Prescription Drug Plan	14,063	-	-
Total	979,506	1,252,649	1,236,108

(1) Commercial membership includes corporate accounts, self-funded employers, individual accounts, Medicare Supplement, federal government employees and local government employees.
(2) Enrollment for 2005 and 2004 includes the Metro-North region. The contract for this region was not renewed effective November 1, 2006.

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2006, 2005 and 2004.

(Dollar amounts in millions)	**2006**	**Comparable Basis 2005 (1)**	**2005**	**2004**
Year ended December 31,				
Revenues:				
Premiums earned, net	$ 1,511.6	$ 1,441.8	$ 1,380.2	$ 1,299.0
Administrative service fees	14.1	14.4	14.4	9.2
Net investment income	42.7	39.7	29.1	26.8
Total operating revenues	1,568.4	1,495.9	1,423.7	1,335.0
Net realized investment gains	0.8	11.6	7.2	11.0
Net unrealized investment gain (loss) on trading securities	7.7	(4.7)	(4.7)	3.0
Other income, net	2.3	3.7	3.7	3.4
Total revenues	1,579.2	1,506.5	1,429.9	1,352.4
Benefits and expenses:				
Claims incurred	1,259.0	1,237.3	1,208.3	1,115.8
Operating expenses	236.1	213.2	181.7	171.9
Total operating costs	1,495.1	1,450.5	1,390.0	1,287.7
Interest expense	16.6	9.0	7.6	4.6
Total benefits and expenses	1,511.7	1,459.5	1,397.6	1,292.3
Income before taxes	67.5	47.0	32.3	60.1
Income tax expense	13.0	3.1	3.9	14.3
Net income	$ 54.5	$ 43.9	$ 28.4	$ 45.8

(1) Comparable basis information was determined by adding the historical statements of earnings for us and, for the period from February 1, 2005 to December 31, 2005, for GA Life, the same months during which we consolidated GA Life in 2006. Comparable basis information is presented in order to provide a more meaningful comparison of the 2006 and 2005 periods. Comparable basis information is not calculated in accordance with U.S. GAAP and is not intended to represent or be indicative of the results of operations that would have been reported by us had the acquisition of GA Life been completed as of January 31, 2005. See the selected pro forma financial information included in note 3 to our consolidated financial statements included elsewhere in this prospectus. Comparable basis information, unlike the pro forma financial information, does not reflect adjustments, such as interest expense, associated with indebtedness incurred in connection with the acquisition. In addition, comparable basis information does not adjust for the inclusion in our 2006 results of results of our coinsurance funds withheld agreement with GA Life during January of that year.

Year ended December 31, 2006 compared with the year ended December 31, 2005

Operating Revenues

Consolidated premiums earned, net and administrative service fees increased $131.1 million, or 9.4%, to $1.5 billion in 2006 compared to 2005. On a comparable basis, including GA Life's results from both periods, consolidated earned premiums, net and administrative service fees increased by $69.5 million, or 4.8%. These increases were primarily due to an increase in our managed care segment, principally due to strong growth from our Medicare Advantage and PDP products, offset in part by the Reform sector due to the loss of the Metro-North region.

Consolidated net investment income increased by $13.6 million, or 46.7%, to $42.7 million in 2006. On a comparable basis, consolidated net investment income increased by $3.0 million, or 7.6%, in 2006. This increase is primarily the result of a higher balance of invested assets and an increase in yield during 2006.

Net realized investment gains

Consolidated net realized investment gains decreased by $6.4 million, or 88.9%, to $0.8 million in 2006. On a comparable basis, consolidated net realized investment gains decreased by $10.8 million, or 93.1%, to $0.8 million in 2006. This decrease is primarily the a result of high levels of sales of investments in 2005 in order to take advantage of a temporary reduction in the capital gains tax rate for sales of long-term capital assets, thus causing relatively significant gains to be realized in the 2005 period.

Net unrealized gain (loss) on trading securities and other income, net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net was $10.0 million during the 2006 period, an increase of $11.0 million on both an actual and comparable basis. This increase is attributable to unrealized equity securities gains in our trading portfolios. The unrealized loss in 2005 arose upon the sale of securities in a gain position to take advantage of the temporary reduction in capital gains tax rate, as discussed above.

Claims Incurred

Consolidated claims incurred during 2006 increased by $50.7 million, or 4.2%, to $1.3 billion in 2006 when compared to the claims incurred from 2005 levels. On a comparable basis, the consolidated claims incurred increased by $21.7 million, or 1.8%, principally due to increased claims in the managed care segment as a result of increased enrollment in the Medicare Advantage and PDP sectors, net of a decrease in the Reform sector. In addition, the loss ratio on a comparable basis decreased by 2.5 percentage points from 85.8% to 83.3%.

Operating Expenses

Consolidated operating expenses during 2006 increased by $54.4 million, or 29.9%, to $236.1 million in the 2006 period as compared to the operating expenses during the 2005 period. On a comparable basis, consolidated operating expenses increased by $22.9 million, or 10.7%, which is attributed primarily to increased volume of business across all of our businesses during the 2006 period. In addition, we experienced normal increases in payroll and related expenses, commission expenses and information technology related costs.

Interest expense

Consolidated interest expense for the year ended December 31, 2006 increased by $9.0 million to $16.6 million. On a comparable basis, consolidated interest expense increased by $7.6 million, primarily due to the interest expense corresponding to new debt incurred during the fourth quarter of 2005 and during the first quarter of 2006 in connection with the GA Life acquisition.

Income tax expense

The consolidated effective tax rate increased by 7.2 percentage points, from 12.1% in 2005 to 19.3% in 2006, primarily due to an increase in taxable investment income, offset in part by an increase in net income relating to the life insurance segment, which has a lower effective tax rate than the other lines of business.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Consolidated premiums earned, net and administrative service fees presented a combined increase of $86.4 million, or 6.6%, to $1.4 billion during 2005, $85.5 million of which was from the managed care segment across many of our products.

Consolidated net investment income increased by $2.3 million, or 8.6%, to $29.1 million during 2005, principally due to a higher balance of invested assets as well as to a higher yield during 2005.

Net realized investment gains

Consolidated net realized investment gains decreased by $3.8 million, or 34.5%, to $7.2 million during 2005, principally due to higher sales of investments in equity securities during 2004.

Net unrealized gain (loss) on trading securities and other income, net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net decreased by $7.4 million, or 115.6%, to a loss of $1.0 million in 2005, primarily reflecting unrealized losses in equity securities. We experienced an unrealized loss in 2005 because, during the second quarter of 2005, we sold certain equity investments with unrealized gains in order to take advantage of a temporary reduction in the capital gains tax rate, thus eliminating the unrealized gains that would have offset the unrealized losses in our portfolios during this period.

Claims Incurred

Consolidated claims incurred increased by $92.5 million, or 8.3%, to $1.2 billion during 2005. This increase was principally driven by fluctuations in the claims incurred by the managed care segment, primarily due to increased utilization, costs of services and enrollment.

Operating Expenses

Consolidated operating expenses increased by $9.8 million, or 5.7%, to $181.7 million in 2005, primarily due to increased business volume and startup costs associated with the launching of our new Medicare Advantage products.

Interest expense

Consolidated interest expense in 2005 period increased by $3.0 million to $7.6 million, primarily due to the interest expense corresponding to new debt incurred by our managed care segment in September 2004.

Income tax expense

The consolidated effective tax rate decreased from 23.8% in 2004 to 12.1% in 2005 due to the net effect of an increase in exempt interest income during 2005, which decreased the effective rate, and an increase in the property and casualty insurance segment's deferred tax expense.

Managed Care Operating Results

We offer our products in the managed care segment to four distinct market sectors in Puerto Rico: commercial, Reform, Medicare Advantage and Medicare Part D stand-alone PDP. The commercial sector represented 47.2%, and the Reform sector represented 30.2%, of our consolidated premiums earned, net during 2006 and 2.4% and 13.8%, respectively, of our operating income for this period. Earned premiums, net and operating income generated from our Medicare Advantage contracts (including PDP) during 2006 represented 11.3% and 45.9% of our consolidated earned premiums, net and operating income, respectively.

(Dollar amounts in millions, except enrollment data)	2006	2005	2004
Year ended December 31,			
Medical operating revenues:			
Medical premiums earned, net:			
Commercial	$ 713.2	$ 734.5	$ 714.5
Reform	455.8	510.8	484.7
Medicare Advantage	155.7	34.2	—
PDP	15.1	—	—
Medical premiums earned	1,339.8	1,279.5	1,199.2
Administrative service fees	16.9	15.5	10.3
Net investment income	18.8	17.0	16.0
Total medical operating revenues	1,375.5	1,312.0	1,225.5
Medical operating costs:			
Medical claims incurred	1,173.6	1,155.9	1,058.6
Medical operating expenses	156.4	140.0	130.7
Total medical operating costs	1,330.0	1,295.9	1,189.3
Medical operating income	$ 45.5	$ 16.1	$ 36.2
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	5,272,987	5,632,249	5,755,380
Self funded	1,861,833	1,840,716	1,692,108
Total commercial member months	7,134,820	7,472,965	7,447,488
Reform	6,484,270	7,465,777	7,377,048
Medicare Advantage	281,274	71,947	—
PDP	180,444	—	—
Total member months	14,080,808	15,010,689	14,824,536
Medical loss ratio	87.6%	90.3%	88.3%
Operating expense ratio	11.5%	10.8%	10.8%

Year ended December 31, 2006 compared with the year ended December 31, 2005

Medical Operating Revenues

Medical premiums earned during 2006 increased by $60.3 million, or 4.7%, to $1.3 billion when compared to earned premiums during 2005, principally as a result of the following:

- Medical premiums generated by the Medicare Advantage business increased during 2006 by $121.5 million, or 355.3%, primarily due to an increase in member months enrollment of 209,327, or 290.9%, reflecting the initial ramp-up of this business, which commenced in 2005, and the introduction of additional Medicare Advantage policies. In January 2006, we expanded our Medicare Advantage business with the introduction of Medicare Platino for the dual-eligible population, the medically indigent Medicare-qualified beneficiaries. We expect that Medicare Advantage enrollment will continue to experience significant growth, but at a substantially slower pace than in this initial period.

- In January 2006, we introduced a new PDP, FarmaMed, which had member months enrollment of 180,444 and premiums of $15.1 million during the 2006 period. In 2006, membership of our PDP business transferred in material numbers to one of our Medicare Advantage policies. We expect this trend to continue in 2007 and, as a result, to

experience a decrease in the enrollment of this business.

- During 2006, member months enrollment in the Reform business decreased by 981,507, or 13.1%, and premiums earned during the year decreased by $55.0 million, or 10.8%. This business experienced a decrease in its member months as a result of the loss of the Metro-North region effective November 1, 2006. Monthly premiums earned from the Metro-North region averaged approximately $16.2 million in 2006. In addition, this business also experienced a shift in membership by dual eligibles to Medicare Advantage policies offered by us and our competitors and a tightening of membership restrictions by the Puerto Rico government. The effect of this decrease in membership was mitigated by an increase in premium rates, effective August 1, 2005, of approximately 5.0%.

- Medical premiums generated by the commercial sector decreased by $21.3 million, or 2.9%. This decrease is due to a decrease in member months of 359,262, or 6.4%, primarily as a result of the loss of several fully-insured accounts due to aggressive marketing and pricing by our competitors as well as qualified enrollees transferring to our or our competitors' Medicare Advantage policies and fully-insured groups changing to ASO arrangements, offset in part by an average increase in premium rates of approximately 3.7%.

Administrative service fees increased by $1.4 million, or 9.0%, to $16.9 million during the 2006 period due to an increase in member months enrollment of ASO arrangements of 21,117, or 1.1%, and increases in fee rates.

Medical Claims Incurred

Medical claims incurred during 2006 increased by $17.7 million, or 1.5%, to $1.2 billion when compared to 2005. The increase in medical claims incurred is mostly related to the medical claims incurred of the Medicare Advantage and PDP businesses, which increased by $92.7 million during the 2006 period due to an increase in members, mitigated by a decrease of $66.7 million in medical claims incurred related to the decreased enrollment of the Reform business. The medical loss ratio decreased by 2.7 percentage points during the 2006 period, to 87.6%, primarily driven by lower utilization trends in the Reform business and the increased relative contribution in the 2006 period of our Medicare Advantage business, which has had a lower medical loss ratio than our other businesses. We do not expect this trend in our medical loss ratio to continue in 2007, largely due to expected increases in the medical loss ratio of our Medicare Advantage line as that business matures.

Medical Operating Expenses

Medical operating expenses for 2006 increased by $16.4 million, or 11.7%, to $156.4 million when compared to 2005. This increase is primarily attributed to additional administrative costs related to the growth of our Medicare Advantage business of approximately $9.8 million and an increase of $4.4 million in technology-related costs and ordinary course payroll and payroll related increases. The segment's operating expense ratio increased by 0.7 percentage points during the 2006 period.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Medical Operating Revenues

Medical premiums earned, net increased by $80.3 million, or 6.7%, to $1.3 billion during 2005, primarily as a result of the following:

- Medical premiums earned of the Medicare Advantage business, which began operating in 2005, amounted to $34.2 million. During 2005 the Medicare Advantage sector had a member months enrollment of 71,947.

- Medical premiums earned of the Reform sector increased by $26.1 million, or 5.4%, during 2005. The increase in the medical premiums earned of this business is the result of an increase in average premium rates of 4.5% and an increase in member months enrollment of 88,729, or 1.2%, due to an increase in the number of Reform eligibles.

- Medical premiums earned of the commercial sector increased by $20.0 million, or 2.8%, during 2005 due to the net effect of a 6.0% increase in average premium rates and a decrease in member months enrollment of 123,131, or 2.1%. The decrease in enrollment is primarily due to a continuation of the trend of employers shifting their groups from fully-insured to ASO arrangements and a decrease in the member months enrollment of local government employees and individual accounts as retirees change to Medicare Advantage policies.

Administrative service fees increased by $5.2 million, or 50.5%, to $15.5 million during the 2005 period due to an increase in member months enrollment of ASO arrangements of 148,608, or 8.8%, and an increase in the rates charged to certain of these groups.

Medical Claims Incurred

Medical claims incurred during 2005 increased by $97.3 million, or 9.2%, to $1.2 billion in 2005 due to increased enrollment and an increase in claims experience trends. The medical loss ratio increased by 2.0 percentage points during the same period, from 88.3% in 2004 to 90.3% in 2005, principally driven by higher utilization levels and costs per service in the Reform business, particularly with respect to cardiovascular services, dialysis, obstetrics, office

visits, prescription drugs, laboratory services and specialized procedures, such as MRIs and CT scans. The medical claims incurred of the Reform and commercial businesses increased by $40.2 million and $57.1 million, respectively, in 2005. Medical claims experience trends in the commercial sector increased from 5.7% in 2004 to 6.7% in 2005.

Medical Operating Expenses

Medical operating expenses increased by $9.3 million, or 7.1%, to $140.0 million in 2005 principally due to expenses amounting to $9.4 million related to the launch of the new Medicare Advantage product, new business generated during the year and the commencement of preparations to comply with Sarbanes-Oxley Section 404, offset in part by a reduction of approximately $2.8 million in expenses related to several operating projects that were completed during 2005 but had been ongoing during most of 2004, such as changes due to the requirements of HIPAA. The medical operating expense ratio was unchanged at 10.8% in 2004 and 2005.

Life Insurance Operating Results

(Dollar amounts in millions)	**2006**	**Comparable Basis 2005 (1)**	**2005**	**2004**
Year ended December 31,				
Operating revenues:				
Premiums earned, net				
Premiums earned	$ 91.9	$ 87.9	$ 24.2	$ 23.7
Premiums earned ceded	(9.7)	(10.1)	(8.0)	(7.8)
Assumed premiums earned	4.4	0.4	0.4	—
Net premiums earned	86.6	78.2	16.6	15.9
Commission income on reinsurance	0.3	0.5	0.5	0.5
Premiums earned, net	86.9	78.7	17.1	16.4
Net investment income	13.7	13.6	3.0	2.8
Total operating revenues	100.6	92.3	20.1	19.2
Operating costs:				
Policy benefits and claims incurred	43.6	37.9	8.9	11.2
Underwriting and other expenses	45.8	39.7	8.2	7.4
Total operating costs	89.4	77.6	17.1	18.6
Operating income	$ 11.2	$ 14.7	$ 3.0	$ 0.6
Additional data:				
Loss ratio	50.2%	48.2%	52.0%	68.3%
Operating expense ratio	52.7%	50.4%	48.0%	45.1%

(1) Comparable basis information was determined by adding the historical statements of earnings for us and, for the period from February 1, 2005 to December 31, 2005, for GA Life, the same months during which we consolidated GA Life in 2006. Comparable basis information is presented in order to provide a more meaningful comparison of the 2006 and 2005 periods. Comparable basis information is not calculated in accordance with U.S. GAAP and is not intended to represent or be indicative of the results of operations that would have been reported by us had the acquisition of GA Life been completed as of January 31, 2005. See the selected pro forma financial information included in note 3 to our consolidated financial statements included elsewhere in this prospectus. Comparable basis information, unlike the pro forma financial information, does not reflect adjustments, such as interest expense, associated with indebtedness incurred in connection with the acquisition. In addition, comparable basis information does not adjust for the inclusion in our 2006 results of results of our coinsurance funds withheld agreement with GA Life during January of that year.

Year ended December 31, 2006 compared with the year ended December 31, 2005

Operating Revenues

Premiums earned net for the segment increased by $67.7 million, or 279.8%, to $91.9 million in 2006 compared to 2005, principally reflecting the acquisition of GA Life in 2006. On a comparable basis, premiums earned during 2006 increased by $4.0 million, or 4.6%. This increase is primarily the result of an increase in the life business attributed to an increase in sales of new ordinary life and monthly debt ordinary insurance (MDO) policies, as well as an increase in the cancer and other dreaded diseases business.

On December 22, 2005, we entered into a coinsurance funds withheld agreement with GA Life pursuant to which our former subsidiary SVTS assumed 69% of all the business written by GA Life (prior to its acquisition by us) as of and after the effective date of the agreement. We acquired GA Life effective January 31, 2006, and our results reflect premiums assumed under this agreement of $4.4 million, which represents our share of premiums for the month of January 2006. The effects of the reinsurance transactions corresponding to this agreement were eliminated for consolidated financial statement purposes for the period following January 31, 2006.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred in 2006 increased by $34.7 million, or 389.9%, to $43.6 million in the 2006 period when compared to the 2005 period. On a comparable basis, policy benefits and claims incurred increased by $5.7 million, or 15.0%, due in part to our share of claims and actuarial reserves for the month of January 2006 under the coinsurance agreement with GA Life amounting to $2.3 million. In addition, this segment also experienced increases in death benefits, policy surrenders and policy reserves of approximately $3.6 million, primarily as the result of new sales in the ordinary life and MDO business and to the natural growth of actuarial reserves with respect to aging policies. The latter factor was principally responsible for the increase in the loss ratio on a comparable basis by 2.0 percentage points, from 48.2% in 2005 to 50.2% in 2006.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased from $8.2 million to $45.8 million in 2006 period. On a comparable basis, underwriting and other expenses increased by $6.1 million, or 15.4%. The segment's operating expense ratio on a comparable basis increased by 2.3 percentage points, from 50.4% in 2005 to 52.7% in 2006. The increase in underwriting and other expenses includes $1.8 million relating to our share of commissions and other operating expenses for the month of January 2006 under the coinsurance agreement with GA Life. The remaining increase in operating expenses is mostly related to management fees charged by TSM and an increase in amortization expense resulting from deferred policy acquisition costs and value of business acquired arising from the acquisition of GA Life.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Premiums earned increased by $0.5 million, or 2.1%, to $24.2 million in 2005 as compared to 2004, primarily as a result of an increase in the cancer and other dreaded diseases line of business, which was introduced in the second half of 2004, offset in part by a decrease in the group life line of business due to the termination of a major group with an adverse history of losses.

On December 22, 2005, we entered into a coinsurance funds withheld reinsurance agreement with GA Life pursuant to which GA Life assumed 69% of all business written as of and after the effective date of the agreement. During December 2005, we recorded assumed premiums related to this agreement amounting to $0.4 million.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred decreased by $2.3 million, or 20.5%, to $8.9 million in 2005, primarily as a result of the termination or non-renewal of unprofitable groups. As a result, the loss ratio decreased by 16.3 percentage points, from 68.3% in 2004 to 52.0% in 2005.

Underwriting and Other Expenses

Underwriting and other expenses increased by $0.8 million, or 10.8%, to $8.2 million in 2005, primarily due to increase in commission and other related expenses in the cancer and other dreaded diseases line of business. The operating expense ratio increased by 2.9 percentage points, from 45.1% in 2004 to 48.0% in 2005.

Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	**2006**	**2005**	**2004**

Year ended December 31,

Operating revenues:			
Premiums earned, net:			
Premiums written	$ 158.9	$ 151.1	$ 141.8
Premiums ceded	(65.7)	(59.2)	(52.2)
Change in unearned premiums	(4.7)	(5.1)	(3.4)
Premiums earned, net	88.5	86.8	86.2
Net investment income	9.6	8.7	7.7
Total operating revenues	98.1	95.5	93.9
Operating costs:			
Claims incurred	41.7	43.6	46.0
Underwriting and other operating expenses	45.2	39.6	40.2
Total operating costs	86.9	83.2	86.2
Operating income	$ 11.2	$ 12.3	$ 7.7
Additional data:			
Loss ratio	47.1%	50.2%	53.4%
Operating expense ratio	51.1%	45.6%	46.6%
Combined ratio	98.2%	95.8%	100.0%

Year ended December 31, 2006 compared with the year ended December 31, 2005

Operating Revenues

Total premiums written during 2006 increased by $7.8 million, or 5.2%, to $158.9 million, principally as a result of increases in the dwelling and commercial property mono-line, commercial multi-peril and auto physical damage lines of business.

Premiums ceded to reinsurers increased by $6.5 million, or 11.0%, to $65.7 million as a result of an increase in the portion of risk ceded to reinsurers and to increases in the cost of reinsurance, particularly in non-proportional treaties, including catastrophe coverage. The ratio of premiums ceded to premiums written increased by 2.1 percentage points, from 39.2% in 2005 to 41.3% in 2006 as a result of the same factors.

Claims Incurred

Claims incurred in the 2006 period decreased by $1.9 million, or 4.4%, to $41.7 million, [mostly as the result of the segment's efforts to improve the quality of underwriting and improvements in the claims handling process. The loss ratio decreased by 3.1 percentage points during this period, to 47.1%.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses in 2006 increased by $5.6 million, or 14.1%, to $45.2 million. The operating expense ratio increased by 5.5 percentage points during the same period, to 51.1% in 2006. This increase is primarily due to increases in commission expenses due to commission rate increases reflecting market conditions and increased salaries and benefits expenses, as well as costs associated with the implementation of new IT systems.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Total premiums written increased by $9.3 million, or 6.6%, to $151.1 million in 2005, primarily due to increases in the commercial multi-peril package and auto physical damage lines of business.

Premiums ceded to reinsurers increased by $7.0 million, or 13.4%, to $59.2 million in 2005, primarily as a result of an increase in business volume. The ratio of premiums ceded to total premiums written increased by 2.4 percentage points, from 36.8% in 2004 to 39.2% in 2005, as a result of an increase in the portion of risk ceded to reinsurers, particularly in the commercial and personal lines quota share arrangements, as well as increases in the cost of reinsurance.

Claims Incurred

Claims incurred decreased by $2.4 million, or 5.2%, to $43.6 million in 2005. The loss ratio decreased by 3.2 percentage points, to 50.2% in 2005. These decreases are primarily due to net losses of $2.1 million incurred in 2004 from the effects of Tropical Storm Jeanne in September 2004.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses decreased by $0.6 million, or 1.5%, to $39.6 million in 2005, and the operating expense ratio decreased by 1.0 percentage points, to 45.6% in 2005.

Liquidity and Capital Resources

Cash Flows

A summary of our major sources and uses of cash for the periods indicated is presented in the following table:

(Dollar amounts in millions)	**2006**	**2005**	**2004**
Year ended December 31,			
Sources of cash:			
Cash provided by operating activities	$ 73.7	$ 49.1	$ 8.8
Proceeds from long-term borrowings	35.0	60.0	50.0
Proceeds from short-term borrowings	117.8	174.1	20.4
Proceeds from annuity contracts	6.0	11.5	11.0
Other	—	3.9	6.8
Total sources of cash	232.5	298.6	97.0
Uses of cash:			
Net purchases of investment securities	(7.6)	(92.9)	(41.5)
Acquisition of GA Life, net of cash acquired	(27.8)	—	—
Capital expenditures	(11.9)	(7.6)	(3.5)
Dividends	(6.2)	—	—
Payments of long-term borrowings	(2.5)	(5.1)	(2.6)
Payments of Short-term borrowings	(119.5)	(174.0)	(57.4)
Surrenders of annuity contracts	(16.0)	(5.1)	(4.6)
Other	(8.7)	—	—
Total uses of cash	(200.2)	(284.7)	(109.6)
Net increase (decrease) in cash and cash equivalents	$ 32.3	$ 13.9	$ (12.6)

Year ended December 31, 2006 compared to year ended December 31, 2005

Cash provided by operating activities increased by $24.6 million, or 50.1%, to $73.7 million during 2006, principally due to a 10% increase in premiums collected, offset in part by a 4% increase in claims losses and benefits paid, reflecting primarily lower utilization trends in the managed care segment during 2006. In addition, our operating cash flows during 2006 include the operating cash flows of GA Life, which were not present in prior years. This increase in cash was offset in part by a decrease in net proceeds from sales of our trading portfolio following the sale of $71.9 million of our corporate bond trading portfolio during 2005.

Proceeds from long-term borrowings amounted to $35.0 million during 2006 as a result of the issuance and sale of our 6.7% senior unsecured notes during the first quarter of 2006. These proceeds were used for the acquisition of GA Life.

Net purchases of investment securities decreased by $85.3 million during the 2006 period, primarily as a result of 2005 acquisitions of available-for-sale securities with the proceeds from the sale of our corporate bond trading portfolio.

On January 31, 2006, we acquired GA Life at a cost of $27.8 million, net of $10.4 million of cash acquired.

Capital expenditures increased by $4.3 million as a result of the renovation of a building adjacent to our corporate headquarters as well as costs related to the acquisition by our property and casualty insurance segment of an insurance application and hardware to manage its operations.

On January 13, 2006, we declared and paid dividends to our shareholders amounting to $6.2 million.

The 2006 period reflects net surrenders of annuity contracts of $10.0 million while the 2005 period presents net proceeds from annuity contracts of $6.4 million. This fluctuation is principally due to an increase in the amount of annuity surrenders and a decrease in the proceeds received from the fixed deferred annuity product in the 2006 period.

Year ended December 31, 2005 compared to year ended December 31, 2004

Cash provided by operating activities increased by $40.3 million during 2005 to $49.1 million, principally due to an increase in 2005 of the net proceeds received from sales of our corporate bond trading portfolio, offset by an increase in claims, losses and benefits paid at a higher rate than the premiums collected during 2005. During 2005, the amount of claims, losses and benefits paid increased by 9% while the amount of premiums collected increased by 7%. The fluctuation in the increase in the amount of claims, losses and benefits paid over premiums collected is primarily due to the higher utilization and cost trends experienced by the managed care segment during 2005.

Proceeds from long-term borrowings increased by $10.0 million during 2005 due to the net effect of the $60.0 million proceeds received from the issuance and sale of our 6.6% senior unsecured notes in December 2005 and the $50.0 million proceeds received from the issuance and sale of our managed care subsidiary's 6.3% senior unsecured notes in September 2004 to repay, among other things, short term borrowings.

Net purchases of investments increased by $51.4 million during 2005 principally as a result of investments in available-for-sale securities with the net proceeds obtained from the sale of our corporate bond trading portfolio.

Capital expenditures increased by $4.1 million in 2005 in connection with the renovation of one of our properties and the acquisition of an insurance operations system by our property and casualty insurance segment.

Net payments of short-term debt decreased by $37.1 million as a result of the repayment of short-term borrowings incurred by us in 2003 to pay the tax liability related to the closing agreement with the Puerto Rico Treasury Department (PRTD) upon the termination of our tax exemption. This repayment was made with the proceeds of the long-term debt described above.

Financing and Financing Capacity

We have several short-term facilities available to meet our liquidity needs. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2006, we had $53.0 million of available credit under these facilities. There were no outstanding short-term borrowings under these facilities as of December 31, 2006. Outstanding borrowings under these short-term facilities as of December 31, 2005 amounted to $1.7 million, which were paid out of our operating cash flows in 2006.

As of December 31, 2006, we had the following senior unsecured notes payable:

- On January 31, 2006, we issued and sold $35.0 million of our 6.7% senior unsecured notes payable due January 2021 (the 6.7% notes). The 6.7% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. The proceeds obtained from this issuance were used to finance the acquisition of 100% of the common stock of GA Life effective January 31, 2006.

- On December 21, 2005, we issued and sold $60.0 million of our 6.6% senior unsecured notes due December 2020 (the 6.6% notes). The 6.6% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at

par, in whole or in part, as determined by us. The proceeds obtained from this issuance were used to pay the initial ceding commission to GA Life on the effective date of the coinsurance funds withheld reinsurance agreement.

- On September 30, 2004, we issued and sold $50.0 million of its 6.3% senior unsecured notes due September 2019 (the 6.3% notes). The 6.3% notes are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us. The notes were privately placed to various institutional accredited investors. The notes pay interest semiannually until the principal becomes due and payable. These notes can be prepaid after five years at par, in whole or in part, as determined by our managed care subsidiary. Most of the proceeds obtained from this issuance were used to repay $37.0 million of short-term borrowings. The remaining proceeds were used for general business purposes.

The 6.30% notes, the 6.60% notes and the 6.70% notes contain certain covenants. At March 31, 2007, we and our managed care subsidiary, as applicable, are in compliance with these covenants.

In addition, we are a party to two secured term loans with a commercial bank, FirstBank Puerto Rico. These secured loans bear interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus a margin specified at the time of the agreement. As of December 31, 2006, the two secured loans had outstanding balances of $27.6 million and $10.5 million, respectively, and average annual interest rates of 6.1% and 6.4%, respectively. The first secured loan requires monthly principal repayment of $0.1 million. The second secured loan requires repayment of principal amounts of not less than $0.3 million and integral multiples of $0.1 million in excess thereof and must be repaid by August 1, 2007.

These secured loans are guaranteed by a first lien on our land, buildings and substantially all leasehold improvements, as collateral for the term of the agreements under a continuing general security agreement. These secured loans contain certain covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2006, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loans' outstanding balances. Principal repayments on these loans are expected to be paid out from our operating and investing cash flows.

We have an interest rate swap agreement, which changes the variable rate of one of our credit agreements and fixes the rate at 4.72%. We continually monitor existing and alternative financing sources to support our capital and liquidity needs.

We anticipate that we will have sufficient liquidity to support our currently expected needs.

Planned Capital Expenditures

During 2005, our managed care business began a project to change a significant part of its operations computer system. This project is expected to cost approximately $40.0 million and is expected to be completed by 2011. Our managed care business expects to incur costs of approximately $15.6 million during 2007 in this project. We estimate that $11.3 million of the costs incurred in 2007 will be capitalized over the system's useful life and the remaining amount will be expensed. This amount is expected to be paid out of the operating cash flows of our managed care business.

Contractual Obligations

Our contractual obligations impact our short and long-term liquidity and capital resource needs. However, our future cash flow prospects cannot be reasonably assessed based solely on such obligations. Future cash outflows, whether contractual or not, will vary based on our future needs. While some cash outflows are completely fixed (such as commitments to repay principal and interest on borrowings), most are dependent on future events (such as the payout pattern of claim liabilities which have been incurred but not reported).

The table below describes the payments due under our contractual obligations, aggregated by type of contractual obligation, including the maturity profile of our debt, operating leases and other long-term liabilities, and excludes an estimate of the future cash outflows related to the following liabilities:

- Liability for future policy benefits – This liability was excluded because we do not expect to make payments in the future until the occurrence of an insurable event, such as death or disability, and because the occurrence of a payment triggering event, such as the surrender of a policy or contract, is not under our

control. The determination of the timing of payment of this liability is not reasonably fixed and determinable since the insurable event has not yet occurred. As of December 31, 2006, our liability for future policy benefits amounted to $180.4 million.

- Unearned premiums – This amount accounts for the premiums collected prior to the end of the coverage period and does not represent a future cash outflow. As of December 31, 2006, we had $113.6 million in unearned premiums.

- Policyholder deposits – The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2006, our policyholder deposits had a carrying amount of $45.4 million.

- Other long-term liabilities – Due to the indeterminate timing of their cash outflows, $56.2 million of other long-term liabilities are not reflected in the following table, including $32.3 million of liability for pension benefits and $13.6 million in liabilities to the Federal Employees Health Benefit Plan.

		Contractual obligations by year						
(Dollar amounts in millions)	**Total**	**2007**	**2008**	**2009**	**2010**	**2011**	**Thereafter**
Long-term borrowings [1]	$ 326.8	$ 23.7	$ 12.7	$ 12.5	$ 12.5	$ 12.4	$ 253.0
Operating leases	16.8	4.6	3.6	3.1	2.6	2.7	0.2
Purchase obligations [2]	135.5	132.0	0.3	0.5	0.4	0.4	1.9
Claim liabilities [3]	282.6	193.0	50.9	11.6	10.2	6.5	10.4
	$ 761.7	$ 353.3	$ 67.5	$ 27.7	$ 25.7	$ 22.0	$ 265.5

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(1) As of December 31, 2006, our long-term borrowings consist of our managed care subsidiary's 6.30% senior unsecured notes payable (which are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us), our 6.60% senior unsecured notes payable, our 6.70% senior unsecured notes payable, and loans payable to a commercial bank. Total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.30%, 6.60% and 6.70% senior unsecured notes, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2019, 2020, and 2021, respectively. We may redeem the notes starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loans payable were estimated using the interest rate applicable as of December 31, 2006 for each of the loans. The actual amount of interest payments of the loans payable will differ from the amount included in this schedule due to the loans' variable interest rate structure. See the "— Financing and Financing Capacity" section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan contributions amounting to $5.0 million were included within the total purchase obligations. However, this amount is an estimate which may be subject to change in view of the fact that contribution decisions are affected by various factors such as market performance, regulatory and legal requirements and plan funding policy.

(3) Claim liabilities represent the amount of our claims processed and incomplete as well as an estimate of the amount of incurred but not reported claims and loss-adjustment expenses. This amount does not include an estimate of claims to be incurred subsequent to December 31, 2006. The expected claims payments are an estimate and may not necessarily present the actual claims payments to be made by us. Also, the estimated claims payments included in the table above do not include $32.1 million of reserves ceded under reinsurance contracts. Since reinsurance contracts do

not relieve us from our obligations to policyholders, in the event that any of the reinsurance companies is unable to meet its obligations under the existing reinsurance agreements, we would be liable for such defaulted amounts.

Off-Balance Sheet Arrangements

We have no off-balance sheet arrangements that have or are reasonably likely to have a current or future material effect on our financial condition, revenues, expenses, results of operations, liquidity, capital expenditures or capital resources.

Restriction on Certain Payments by our Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico. These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance

subsidiaries to TSM. Our managed care subsidiary is required to have minimum capital of $1.0 million, our life insurance subsidiary is required to have minimum capital of $2.5 million and our property and casualty insurance subsidiary is required to have minimum capital of $3.0 million. As of December 31, 2006, our insurance subsidiaries were in compliance with such minimum capital requirements.

These regulations are not directly applicable to us, as a holding company, since we are not an insurance company.

Our credit agreements restrict the amount of dividends that we and our subsidiaries can declare or pay to shareholders. Under to the credit agreements, dividend payments cannot be made in excess of the accumulated retained earnings of the paying entity.

We do not expect that any of the previously described dividend restrictions will have a significant effect on our ability to meet our cash obligations.

Solvency Regulation

To monitor the solvency of the operations, the BCBSA requires us and our managed care subsidiary to comply with certain specified levels of RBC. RBC is designed to identify weakly capitalized companies by comparing each company's adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2006, our managed care subsidiary's estimated RBC ratios was above the 200% of the RBC required by the BCBSA and the 375% of the RBC required by the BCBSA to avoid monitoring.

Other Contingencies

Legal Proceedings

Various litigation claims and assessments against us have arisen in the course of our business, including but not limited to, our activities as an insurer and employer. Furthermore, the Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations.

Based on the information currently known by our management, in its opinion, the outcomes of such pending investigations and legal proceedings are not likely to have a material adverse effect on our financial position, results of operations and cash flows. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could, from time to time, have an adverse effect on our operating results and/or cash flows. See "Business — Legal Proceedings."

Guarantee Associations

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared to be insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. During 2006, 2005 and 2004, we paid assessments in connection with insurance companies declared insolvent in the amount of $0.8 million, $1.0 million and $1.1 million, respectively. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria

(SIMED) and of the Sindicato de Aseguradores de Responsabilidad Profesional para Médicos. Both syndicates were organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the previously mentioned syndicates cannot meet their obligations. During 2006, 2005 and 2004, no assessment or payment was made for this contingency. It is the opinion of management that any

possible future syndicate assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

In addition, pursuant to Article 12 of Rule LXIX of the Insurance Code, our property and casualty insurance subsidiary is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). The Association was organized in 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, the segment shares the risk proportionally with other members based on a formula established by the Insurance Code. During the three-year period ended December 31, 2006, the Association distributed good experience refunds. The segment received refunds amounting to $0.8 million, $0.9 million and $0.8 million in 2006, 2005, and 2004, respectively.

Critical Accounting Policies and Estimates

Our consolidated financial statements and accompanying notes included in this prospectus have been prepared in accordance with U.S. generally accepted accounting principles applied on a consistent basis. The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. We continually evaluate the accounting policies and estimates we use to prepare our consolidated financial statements. In general, management's estimates are based on historical experience and various other assumptions it believes to be reasonable under the circumstances. The following is an explanation of our accounting policies considered most significant by management. These accounting policies require us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information is known. Actual results could differ materially from those estimates.

The policies discussed below are considered by management to be critical to an understanding of our financial statements because their application places the most significant demands on management's judgment, with financial reporting results relying on estimation about the effect of matters that are inherently uncertain. For all these policies, management cautions that future events may not necessarily develop as forecasted, and that the best estimates routinely require adjustment. Management believes that the amounts provided for these critical accounting estimates are adequate.

Claim Liabilities

Claim liabilities as of December 31, 2006 by segment were as follows:

(Dollar amounts in millions)	**Managed Care**	**Life Insurance**	**Property and Casualty Insurance**	**Consolidated**
Claims processed and incomplete [1]	$ 72.0	$ 26.3	$ 48.9	$ 147.2
Unreported losses [2]	108.0	8.5	34.2	150.7
Unpaid loss-adjustments expenses [3]	5.3	0.3	11.2	16.8
	$ 185.3	$ 35.1	$ 94.3	$ 314.7

(1) The liability for claims processed and incomplete represents those claims that have been incurred and reported to us that remain unpaid as of the balance sheet date. This amount includes claims that have been investigated and adjusted but have not been paid as well as those reported claims that have not gone through the investigation and adjustment process.

(2) The liability for estimated unreported losses is the amount needed to provide for the estimated ultimate cost of settling those claims related to insured events that have occurred but have not been reported to us.

(3) The liability for unpaid loss-adjustment expenses is the amount needed to provide for the estimated ultimate cost required to investigate and adjust claims related to insured events that have occurred as of the balance sheet date, whether or not the claims have been reported to us at that date.

Management continually evaluates the potential for changes in its claim liabilities estimates, both positive and negative, and uses the results of these evaluations to adjust recorded claim liabilities and underwriting criteria. Our profitability depends in large part on our ability to accurately predict and effectively manage the amount of claims

incurred, particularly those of the managed care segment and the losses arising from the property and casualty and life insurance segment. Management regularly reviews its premiums and benefits structure to reflect our underlying claims experience and revised actuarial data; however, several factors could adversely affect our underwriting results. Some of these factors are beyond management's control and could adversely affect its ability to accurately predict and effectively control claims incurred. Examples of such factors include changes in health practices, economic conditions, change in utilization trends, healthcare costs, the advent of natural disasters, and malpractice litigation. Costs in excess of those anticipated could have a material adverse effect on our results of operations.

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2006, claim liabilities for the managed care segment amounted to $185.3 million and represented 58.9% of our total consolidated claim liabilities and 18.5% of our total consolidated liabilities.

Liabilities for reported but incomplete claims are recorded at the contractual rate. Liabilities for unreported losses are determined employing actuarial methods that are commonly used by managed care actuaries and meet Actuarial Standards of Practice, which require that the claim liabilities be adequate under moderately adverse circumstances. The segment determines the amount of the liability for unreported losses by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project a best estimate of claim liabilities. Under this process, historical claims incurred dates are compared to actual dates of claims payment. This information is analyzed to create "completion" or "development" factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the total expected claims incurred.

The majority of unpaid claims, both reported and unreported, for any period are those claims which are incurred in the final months of the period. Since the percentage of claims paid during the period with respect to claims incurred in those months is generally very low, the above-described completion factor methodology is less reliable for such months. In order to complement the analysis to determine the unpaid claims, historical completion factors and payment patterns are applied to incurred and paid claims for the most recent twelve months and compared to the prior twelve month period. Incurred claims for the most recent twelve months also take into account recent claims expense levels and health care trend levels (trend factors). Using all of the above methodologies, our actuaries determine based on the different circumstances the unpaid claims as of the end of any period.

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed.

Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns and claim submission patterns. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 75% of the claims are paid the first quarter following the incurrence date and about 10% are paid during the second quarter, for a total of 85% paid during the first six months following the

incurrence date.

Management regularly reviews its assumptions regarding claim liabilities and makes adjustments to claims incurred when necessary. If management's assumptions regarding cost trends and utilization are significantly different than actual results, our statement of earnings and financial position could be impacted in future periods. Changes to prior year estimates may result in an increase in claims incurred or a reduction of claims incurred in the

period the change is made. Further, due to the considerable variability of health care costs, adjustments to claims liabilities are made in each period and are sometimes significant as compared to the net income recorded in that period. Prior year development of claim liabilities is recognized immediately upon the actuary's judgment that a portion of the prior year liability is no longer needed or that an additional liability should have been accrued. Health care trends are monitored in conjunction with the claim reserve analysis. Based on these analyses, rating trends are adjusted to anticipate future changes in health care cost or utilization. Thus, the managed care segment incorporates those trends as part of the development of premium rates in an effort to keep premium rating trends in line with claims trends.

As described above, completion factors and trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2006 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

Completion Factor [1] (Decrease) Increase		**Claims Trend Factor [2] (Decrease) Increase**	
In completion factor	**In unpaid claim liabilities**	**In claims trend factor**	**In unpaid claim liabilities**
(0.6)%	$7.2	(0.6)%	$9.3
(0.4)%	4.8	(0.4)%	6.2
(0.2)%	2.4	(0.2)%	3.1
0.2%	(2.4)	0.2%	(3.1)
0.4%	(4.7)	0.4%	(6.2)
0.6%	(7.1)	0.6%	(9.3)

(1) Assumes (decrease) increase in the completion factors for the most recent twelve months.

(2) Assumes (decrease) increase in the claims trend factors for the most recent twelve months.

The segments' reserving practice is to consistently recognize the actuarial best estimate as the ultimate liability for claims within a level of confidence required by actuarial standards. Management believes that the methodology for determining the best estimate for claim liabilities at each reporting date has been consistently applied.

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out, becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimated. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a "short tail", which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 95%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 5% related to claims incurred prior to the previous calendar year-end. In 2004, the managed care segment's claim payment patterns were affected by a slowdown in claims submission from providers due to HIPAA coding changes that occurred during the latter half of 2003 and by the effect of tropical storm Jeanne, which limited access to providers during the months of September and October 2004. The

first event affects historical completion factors while the second event changed utilization trends. Management has not noted any significant emerging trends in claim frequency and severity, other than those described above, and the normal fluctuation in utilization trends from year to year.

The following table shows the variance between the segment's incurred claims for current period insured events and the incurred claims for such years had they been determined retrospectively (the "Incurred claims related to current period insured events" for the year shown plus or minus the "Incurred claims related to prior period insured events" for the following year). This table shows that the segments' estimates of this liability have approximated the actual development.

(Dollar amounts in millions)	**2006**	**2005**	**2004**	**2003**
Total incurred claims:				
As recorded for current period insured events [1]	$ 1,184.3	$ 1,148.2	$ 1,062.7	$ 1,026.0
On a retrospective basis [2]	1,171.7	1,137.5	1,070.4	1,021.9
Variance	$ 12.6	$ 10.7	$ (7.7)	$ 4.1
Variance to total incurred claims as reported	1.1%	0.9%	(0.7)%	0.4%

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(1) Includes total claims incurred less adjustments for prior year reserve development.

(2) The incurred claims on a retrospective basis for the 2006 period was estimated using the reserve development observed during the three-month period ended March 31, 2007. This amount could differ once the ultimate development during 2007 is known.

Management expects that substantially all of the development of the 2006 estimate of medical claims payable will be known during 2007 and that the variance of the total incurred claims on a retrospective basis when compared to reported incurred claims will be similar to the prior years.

In the event this segment experiences an unexpected increase in health care cost or utilization trends, we have the following options to cover claim payments:

- Through the management of our cash flows and investment portfolio.

- We have the ability to increase the premium rates throughout the year in the monthly renewal process, when renegotiating the premiums for the following contract year of each group as they become due. We consider the actual claims trend of each group when determining the premium rates for the following contract year.

- We have available short-term borrowing facilities that from time to time address differences between cash receipts and disbursements.

For additional information on our credit facilities, see section "— Financing and Financing Capacity."

Life Insurance Segment

At December 31, 2006, claim liabilities for the life insurance segment amounted to $35.1 million and represented 11.2% of total consolidated claim liabilities and 3.5% of our total consolidated liabilities.

The claim liabilities related to the life insurance segment are based on methods and underlying assumptions in accordance with GAAP and applicable actuarial standards. The estimate of claim liabilities for this segment is based on the amount of benefits contractually determined and on actuarial estimates of the amount of loss inherent in that period's claims, including losses for which claims have not been reported. This estimate relies on actuarial observations of ultimate loss experience for similar historical events. Principal assumptions used in the establishment of claim liabilities for this segment are mortality, morbidity and claim submission patterns, among others.

Claim reserve reviews are generally conducted on a quarterly basis, in light of continually updated information. Our actuaries review reserves using the current inventory of policies and claims data. These reviews incorporate a variety

of actuarial methods, judgments and analysis.

The key assumption with regard to claim liabilities for our life insurance segment is related to claims incurred prior to the end of the year, but not yet reported to our subsidiary. A liability for these claims is estimated based upon experience with regards to amounts reported subsequent to the end of prior years. There are uncertainties attendant to these estimates; however, in recent years our estimates have proved to be slightly conservative.

Property and Casualty Insurance Segment

At December 31, 2006, claim liabilities for the property and casualty insurance segment amounted to $94.3 million and represented 30.0% of the total consolidated claim liabilities and 9.4% of our total consolidated liabilities.

Estimates of the ultimate cost of claims and loss-adjustment expenses of this segment are based largely on the assumption that past developments, with appropriate adjustments due to known or unexpected changes, are a reasonable basis on which to predict future events and trends, and involve a variety of actuarial techniques that analyze current experience, trends and other relevant factors. Property and casualty insurance claim liabilities are categorized and tracked by line of business. Medical malpractice policies are written on a claims-made basis. Policies written on a claims-made basis require that claims be reported during the policy period. Other lines of business are written on an occurrence basis.

Individual case estimates for reported claims are established by a claims adjuster and are changed as new information becomes available during the course of handling the claim. Our property and casualty business, other than medical malpractice, is primarily short-tailed business, where losses (e.g. paid losses and case reserves) are generally reported quickly.

Claim reserve reviews are generally conducted on a quarterly basis, in light of continually updated information. Our actuaries certify reserves for both current and prior accident years using current claims data. These reviews incorporate a variety of actuarial methods, judgments, and analysis. For each line of business, a variety of actuarial methods are used, with the final selections of ultimate losses that are appropriate for each line of business selected based on the current circumstances affecting that line of business. These selections incorporate input from management, particularly from the claims, underwriting and operations divisions, about reported loss cost trends and other factors that could affect the reserve estimates.

Key assumptions are based on the consideration that past emergence of paid losses and case reserves is credible and likely indicative of future emergence and ultimate losses. A key assumption is the expected loss ratio for the current accident year. This expected loss ratio is generally determined through a review of the loss ratios of prior accident years and expected changes to earned pricing, loss costs, mix of business, and other factors that are expected to impact the loss ratio for the current accident year. Another key assumption is the development patterns for paid and reported losses (also referred to as the loss emergence and settlement patterns). The reserves for unreported claims for each year are determined after reviewing the indications produced by each actuarial projection method, which, in turn, rely on the expected paid and reported development patterns and the expected loss ratio for that year.

At December 31, 2006, the actuarial reserve range determined by the actuaries was from $90.4 million to $101.0 million. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management's consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $4.6 million and $3.6 million, respectively.

Liability for Future Policy Benefits

Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. We compute the amounts for actuarial liabilities in conformity with GAAP.

Liabilities for future policy benefits for whole life and term insurance products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.4% and withdrawal, mortality and morbidity assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health reserves are stated at amounts determined by estimates on individual claims and estimates of unreported

claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions is the level of anticipated death and health claims. Other assumptions that are less significant to the appropriate level of the liability for future policy benefits are anticipated policy persistency rates, investment yields, and operating expense levels. These are reviewed frequently by our subsidiary's external actuaries, to assure that the current level of liabilities for future policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. For all products except for universal life and deferred annuities, according to Statement of Financial Accounting Standards (SFAS) No. 60, *Accounting and Reporting by Insurance Enterprises*, the basis for the liability for future policy benefits is established at the time of issuance of each contract and would only change if our experience deteriorates to the point that the level of the liability is not adequate to provide for future policy benefits. We do not currently expect that level of deterioration to occur.

Deferred Policy Acquisition Costs and Value of Business Acquired

Certain costs for acquiring life and property and casualty insurance business are deferred. Acquisition costs related to the managed care business are expensed as incurred.

The costs of acquiring new life business, principally commissions, and certain variable underwriting, agency and policy issue expenses of our life insurance segment, have been deferred. These costs, including value of business acquired (VOBA) recorded upon our acquisition of GA Life, are amortized to income over the premium-paying period of the related whole life and term insurance policies in proportion to the ratio of the expected annual premium revenue to the expected total premium revenue, and over the anticipated lives of universal life policies in proportion to the ratio of the expected annual gross profits to the expected total gross profits. The expected premiums revenue and gross profits are based upon the same mortality and withdrawal assumptions used in determining the liability for future policy benefits. For universal life policies, changes in the amount or timing of expected gross profits result in adjustments to the cumulative amortization of these costs. The effect on the amortization of deferred policy acquisition costs of revisions to estimated gross profits is reported in earnings in the period such estimated gross profits are revised.

The schedules of amortization of life insurance deferred policy acquisition costs (DPAC) and VOBA are based upon actuarial assumptions regarding future events that are uncertain. For all products, other than universal life and deferred annuities, the most significant of these assumptions is the level of contract persistency and investment yield rates. For these products according to FASB No. 60 the basis for the amortization of DPAC and VOBA is established at the issue of each contract and would only change if our segment's experience deteriorates to the point that the level of the liability is not adequate. We do not currently expect that level of deterioration to occur. For the universal life and deferred annuity products, amortization schedules are based upon the level of historic and anticipated gross profit margins, from the date of each contract's issued (or purchase, in the case of VOBA). These schedules are based upon several actuarial assumptions that are uncertain, are reviewed annually and are modified if necessary. The most significant of these assumptions are anticipated universal life claims, investment yield rates and contract persistency. Based upon the most recent actuarial reviews of all of the assumptions, we do not currently anticipate material changes to the level of these amortization schedules.

The property and casualty business acquisition costs consist of commissions incurred during the production of business and are deferred and amortized ratably over the terms of the policies.

Impairment of Investments

Impairment of an investment exists if a decline in the estimated fair value below the amortized cost of the security is deemed to be other than temporary. An impairment review of securities to determine if impairment exists is subjective and requires a high degree of judgment. Management regularly reviews each investment security for impairment based

on criteria that include the extent to which cost exceeds estimated fair value, general market conditions (like changes in interest rates), our ability and intent to hold the security until recovery in estimated fair value, the duration of the estimated fair value decline and the financial condition and specific prospects for the issuer. Management regularly performs market research and monitors market conditions to evaluate impairment risk. A decline in the estimated fair value of any available-for-sale or held-to-maturity security below cost, which is

deemed to be other than temporary, results in a reduction of the carrying amount to its fair value. The impairment is charged to operations when that determination is made and a new cost basis for the security is established.

During the years ended December 31, 2006 and 2005 we recognized other-than-temporary impairments amounting to $2.1 and $1.1 million, respectively, on one of our equity securities classified as available for sale. No other-than-temporary impairment was recognized in 2004. As of December 31, 2006, of the total amount of investments in securities of $869.1 million, $83.4 million, or 10%, are classified as trading securities, and thus are recorded at fair value with changes estimated fair value recognized in the statement of operations. The remaining $785.7 million is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $664.4 million, or 85%, are securities in U.S. Treasury securities, obligations of U.S. government-sponsored enterprises, obligations of the Commonwealth of Puerto Rico, mortgage backed and collateralized mortgage obligations that are U.S. agency-backed, and obligations of U.S. and Puerto Rico government instrumentalities. The remaining $121.3 million, or 15%, are from corporate fixed and equity securities. Gross unrealized losses as of December 31, 2006 of the available-for-sale and held-to-maturity portfolios amounted to $14.5 million.

The impairment analysis as of December 31, 2006 and 2005 indicated that, other than the equity security for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was other-than-temporarily impaired as of that date; however, several factors are beyond management's control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management's judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income. Taking into account the quality of the securities in the investment portfolio, the amount of unrealized losses within the available-for-sale and held-to-maturity portfolios, and past experience, management believes that, the amount of likely future impairments in the next year should not be material.

Our fixed maturity securities are sensitive to interest rate fluctuations, which impact the fair value of individual securities. Our equity securities are sensitive to equity price risks, for which potential losses could arise from adverse changes in the value of equity securities. For additional information on the sensitivity of our investments, see "— Quantitative and Qualitative Disclosures About Market Risk" in this prospectus.

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2006 and 2005 is included in note 4 to the audited consolidated financial statements.

Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables. The allowance for doubtful receivables amounted to $18.2 million and $12.2 million as of December 31, 2006 and 2005, respectively. The amount of the allowance is based on the age of unpaid accounts, information about the customer's creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

In addition to premium-related receivables, we evaluate the risk in the realization of other accounts receivable, including balances due from third parties related to overpayment of medical claims and rebates, among others. These amounts are individually analyzed and the allowance determined based on the specific collectivity assessment and

circumstances of each individual case.

We consider this allowance adequate to cover potential losses that may result from our inability to subsequently collect the amounts reported as accounts receivable. However, such estimates may change significantly in the event that unforeseen economic conditions adversely impact the ability of third parties to repay the amounts due to us.

Other Significant Accounting Policies

We have other accounting policies that are important to an understanding of the financial statements. See note 2 to the audited consolidated financial statements.

Recently Issued Accounting Standards

SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities*, was issued in February 2007. This statement permits entities to choose to measure many financial instruments and certain other items at fair value that are not currently required to be measured at fair value. The objective of this statement is to improve financial reporting by providing entities with the opportunity to mitigate volatility in reported earnings caused by measuring related assets and liabilities differently without having to apply complex hedge accounting provisions. This statement also establishes presentation and disclosure requirements designed to facilitate comparisons between entities that choose different measurement attributes for similar types of assets and liabilities. This statement does not affect any existing accounting literature that requires certain assets and liabilities to be carried at fair value and does not establish requirements for recognizing and measuring dividend income, interest income, or interest expense. This statement does not eliminate disclosure requirements included in other accounting standards. This statement is effective as of the beginning of an entity's first fiscal year beginning after November 15, 2007. Early adoption is permitted as of the beginning of a fiscal year that begins on or before November 15, 2007, provided the entity also elects to apply the provisions SFAS No. 157, *Fair Value Measurements*. We are currently evaluating the effect of this statement on our consolidated financial statements.

In September 2006, the Securities and Exchange Commission issued Staff Accounting Bulletin (SAB) No. 108 addressing how the effects of prior-year uncorrected financial statement misstatements should be considered in current year financial statements. SAB No. 108 requires registrants to quantify misstatements using both balance sheet and income statement approaches in evaluating whether or not a misstatement is material. SAB No. 108 is effective for fiscal years ended after November 15, 2006. The adoption of this SAB did not have a material impact on our consolidated financial statements.

SFAS No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, was issued in September 2006. This statement changes financial reporting by requiring employers to recognize the overfunded or underfunded status of a defined benefit postretirement plan as an asset or liability in its statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income. This statement also changes financial reporting by requiring employers to measure the funded status of a plan as of the date of its year-end statement of financial position. An employer with publicly traded equity securities is required to initially recognize the funded status of a defined benefit postretirement plan and to provide required disclosures as of the end of the fiscal year ended after December 15, 2006. An employer without publicly traded equity is required to recognize the funded status of a defined benefit pension plan and to provide required disclosures as of the end of the fiscal year ending after June 15, 2007. The requirement to measure plan assets and benefit obligations as of the date of the employer's fiscal year-end statement of financial position is effective for fiscal years ending after December 15, 2008. We adopted the provisions of this statement in the consolidated financial statements as of December 31, 2006 as further discussed in note 18 to our audited consolidated financial statements.

SFAS No. 157, *Fair Value Measurements*, was issued in September 2006. This statement defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. This statement does not require any new fair value measurements; it applies under other accounting statements that require or permit fair value measurements. This statement is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. Except for certain exceptions, the provisions of this statement are to be applied prospectively as of the beginning of the fiscal year in which it is initially

applied. We are currently evaluating the effect of this statement on our consolidated financial statements.

FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes an Interpretation of FASB Statement No. 109*, was issued in June 2006. This Interpretation clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with SFAS No. 109, *Accounting for Income Taxes*. This interpretation prescribes a recognition threshold and measurement attribute for the financial statement

recognition and measurement of a tax position taken or expected to be taken in a tax return. This Interpretation is effective for fiscal years beginning after December 15, 2006. The adoption of this Interpretation is not expected to have a material impact on our consolidated financial statements.

SFAS No. 156, *Accounting for Servicing of Financial Assets*, an amendment of SFAS No. 140, was issued in March 2006. This statement amends SFAS No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, with respect to the accounting for separately recognized servicing assets and servicing liabilities. This Statement is effective as of the beginning of the first fiscal year that begins after September 15, 2006. The adoption of SFAS No. 156 is not expected to have an impact on our consolidated financial statements.

SFAS No. 155, *Accounting for Certain Hybrid Financial Instruments, an amendment of FASB Statements No. 133 and 140*, was issued in February 2006. This statement amends SFAS No. 133, *Accounting for Derivatives and Hedging Activities*, and SFAS No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, and allows an entity to re-measure at fair value a hybrid financial instrument that contains an embedded derivative that otherwise would require bifurcation from the host, if the holder irrevocably elects to account for the whole instrument on a fair value basis. Subsequent changes in the fair value of the instrument would be recognized in earnings. This statement also clarifies certain issues included in the amended SFAS No. 133 and SFAS No. 140. SFAS No. 155 is effective for all financial instruments acquired and issued after the beginning of an entity's first fiscal year that begins after September 15, 2006. The adoption of SFAS No. 155 is not expected to have an impact on our consolidated financial statements.

Quantitative and Qualitative Disclosures About Market Risk.

We are exposed to certain market risks that are inherent in our financial instruments, which arise from transactions entered into in the normal course of business. We are also subject to additional market risk with respect to certain of our financial instruments. We must effectively manage, measure, and monitor the market risk associated with our invested assets and interest rate sensitive liabilities. We have established and implemented comprehensive policies and procedures to minimize the effects of potential market volatility.

Market Risk Exposure

We have exposure to market risk mostly in our investment activities. For purposes of this disclosure, “market risk” is defined as the risk of loss resulting from changes in interest rates and equity prices. Analytical tools and monitoring systems are in place to assess each one of the elements of market risks.

As in other insurance companies, investment activities are an integral part of our business. Insurance statutes regulate the type of investments that the insurance segments are permitted to make and limit the amount of funds that may be invested in some types of securities. We have a diversified investment portfolio with a large portion invested in investment-grade, fixed income securities.

Our investment philosophy is to maintain a largely investment-grade fixed income portfolio, provide adequate liquidity for expected liability durations and other requirements, and maximize total return through active investment management.

We evaluate the interest rate risk of our assets and liabilities regularly, as well as the appropriateness of investments relative to our internal investment guidelines. We operate within these guidelines by maintaining a diversified portfolio, both across and within asset classes.

We have a finance committee, composed of members of the board of directors, which monitors and approves investment policies and procedures. Investment decisions are centrally managed by investment professionals based on the guidelines established by the finance committee. The investment portfolio is managed following those policies and procedures.

Our investment portfolio is predominantly comprised of U.S. Treasury securities, obligations of U.S. government-sponsored enterprises, obligations of state and political subdivisions, obligations of the Commonwealth of Puerto Rico and obligations from U.S. and Puerto Rican government instrumentalities. These investments

comprised approximately 76% of the total portfolio value as of December 31, 2006, of which 12% consisted of U. S. agency-backed mortgage backed securities and collateralized mortgage obligations. The remaining balance of the investment portfolio consists of an equity securities portfolio that seeks to replicate the S&P 500 Index, a large-cap growth index, a large-cap value index, mutual funds, investments in local stocks from well-known financial institutions and investments in corporate bonds.

We use a sensitivity analysis to measure the market risk related to our holdings of invested assets and other financial instruments. This analysis estimates the potential changes in fair value of the instruments subject to market risk. The sensitivity analysis was performed separately for each of our market risk exposures related to our trading and other than trading portfolios. This sensitivity analysis is an estimate and should not be viewed as predictive of our future financial performance. Our actual losses in any particular year could exceed the amounts indicated in the following paragraphs. Limitations related to this sensitivity analysis include:

- the market risk information is limited by the assumptions and parameters established in creating the related sensitivity analysis, including the impact of prepayment rates on mortgages; and
- the model assumes that the composition of assets and liabilities remains unchanged throughout the year.

Accordingly, we use such models as tools and not as a substitute for the experience and judgment of our management.

Interest Rate Risk

Our exposure to interest rate changes results from our significant holdings of fixed maturity securities. Investments subject to interest rate risk are held in our other-than-trading portfolios. We are also exposed to interest rate risk from our two variable interest credit agreements and from our policyholder deposits.

Equity Price Risk

Our investments in equity securities expose us to equity price risks, for which potential losses could arise from adverse changes in the value of equity securities. Financial instruments subject to equity prices risk are held in our trading and other-than-trading portfolios.

Risk Measurement

Trading Portfolio

Our trading securities are a source of market risk. As of December 31, 2006, our trading portfolio was comprised of investments in publicly-traded common stocks. The securities in the trading portfolio are believed by management to be high quality and are diversified across industries and readily marketable. Trading securities are recorded at fair value, and changes in fair value are included in operations. The fair value of the investments in trading securities is exposed to equity price risk. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2006 and 2005, the hypothetical loss in the fair value of these investments would have been approximately $8.3 million and $7.8 million, respectively.

Other than Trading Portfolio

Our available-for-sale and held-to-maturity securities are also a source of market risk. As of December 31, 2006 approximately 92% and 100% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed income securities. The remaining balance of the available-for-sale portfolio is comprised of equity

securities. Available-for-sale securities are recorded at fair value and changes in the fair value of these securities, net of the related tax effect, are excluded from operations and are reported as a separate component of other comprehensive income (loss) until realized. Held-to-maturity securities are recorded at amortized cost and adjusted for the amortization or accretion of premiums or discounts. The fair value of the investments in the other-than-trading portfolio is exposed to both interest rate risk and equity price risk.

Interest Rate Risk. We have evaluated the net impact to the fair value of our fixed income investments of a significant one-time change in interest rate risk using a combination of both statistical and fundamental methodologies. From these shocked values a resultant market price appreciation/depreciation can be determined after portfolio cash flows are modeled and evaluated over instantaneous 100, 200 and 300 basis point rate shifts. Techniques used in the evaluation of cash flows include Monte Carlo simulation through a series of probability distributions over 200 interest rate paths. Necessary prepayment speeds are compiled using Salomon Brothers Yield Book, which sources numerous factors in deriving speeds, including but not limited to: historical speeds, economic indicators, street consensus speeds, etc. Securities evaluated by us under these scenarios include mortgage pass-through certificates and collateralized mortgage obligations of U.S. agencies, and private label structures, provided that cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2006 and 2005.

(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2006:			
Base Scenario	$ 749.7		
+100 bp	716.6	(33.1)	(4.4)%
+200 bp	685.8	(63.9)	(8.5)%
+300 bp	657.1	(92.6)	(12.4)%
December 31, 2005:			
Base Scenario	$ 560.1		
+100 bp	532.4	(27.7)	(4.9)%
+200 bp	512.0	(48.1)	(8.6)%
+300 bp	492.7	(67.4)	(12.0)%

We believe that an interest rate shift in a 12-month period of 100 basis points represents a moderately adverse outcome, while a 200 basis point shift is significantly adverse and a 300 basis point shift is unlikely given historical precedents. Although we classify 88% of our fixed income securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk. Our equity securities in the available-for-sale portfolio are comprised primarily of stock of several Puerto Rican financial institutions and mutual funds. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2006 and 2005, the hypothetical loss in the fair value of these investments would have been approximately $6.2 million and $5.2 million, respectively.

Other Risk Measurement

We are subject to interest rate risk on our two variable interest credit agreements and our policyholder deposits. Shifting interest rates do not have a material effect on the fair value of these instruments. The two credit agreements have a variable interest rate structure, which reduces the potential exposure to interest rate risk. The policyholder deposits have short-term interest rate guarantees, which also reduce the accounts' exposure to interest rate risk.

We have an interest-rate related derivative instrument to manage the variability caused by interest rate changes in the cash flows of one of its credit agreements. This swap changes the variable-rate cash flow exposure on the debt obligations to fixed-rate cash flows. Shifting interest rates have an effect on the fair value of the interest rate swap agreement. We assess interest rate risk by monitoring changes in interest rate exposures that may adversely impact the

fair value of the interest rate swap agreement. We monitor interest rate risk attributable to both our outstanding or forecasted debt obligations as well as our offsetting hedge position. As of December 31, 2006 and 2005, the estimated fair value of the interest rate swap amounted to $0.5 million and $0.6 million, respectively, and was included within "other assets" in the consolidated balance sheets. Assuming an immediate decrease of 10% in period-end rates as of December 31, 2006 and 2005, the hypothetical loss in the estimated fair value of the interest rate swap is estimated to approximate $0.1 million and $0.1 million, respectively.

We have invested in other derivative instruments with a market value of approximately $14.0 million and $13.3 million as of December 31, 2006 and 2005 in order to diversify our investment in securities and participate in foreign stock markets.

In 2005, we invested in two structured note agreements amounting to $5.0 million each, under which the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indices (the Indices). Under these agreements the principal invested by us is protected, the only amount that varies according to the performance of the Indices is the interest to be received upon the maturity of the instruments. Should the Indices experience a negative performance during the holding period of the structured notes, no interest will be received and no amount will be paid to the issuer of the structured notes. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with the provisions of SFAS No. 133, *Accounting for Derivative Instruments and Certain Hedging Activities*, as amended, the embedded derivative component of the structured note is separated from the structured notes and accounted for separately as a derivative instrument. The derivative component of the structured notes exposes us to credit risk and market risk. We minimize credit risk by entering into transactions with counterparties that we believe to be high-quality based on their credit ratings. The market risk is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. As of December 31, 2006 and 2005, the fair value of the derivative component of the structured notes amounted to $6.4 million and $5.3 million, respectively, and is included within “other assets” in the consolidated balance sheets. Assuming an immediate decrease of 10% in the period-end Indices as of December 31, 2006 and 2005, the hypothetical loss in the estimated fair value of the derivative component of the structured notes would have been approximately $0.6 million and $0.5 million, respectively The investment component of the structured notes, which had a fair value of $7.6 million and $8.0 million as of December 31, 2006 and 2005, respectively, is accounted for as a debt security and is included within “investment in securities” in the consolidated balance sheet and its risk measurement is evaluated along the other investments in “— Other than Trading Portfolio” above.

BUSINESS

Company Overview

We are the largest managed care company in Puerto Rico, serving approximately one million members across all regions, and hold a leading market position covering approximately 25% of the population. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico and have over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Medicare and the Reform (similar to Medicaid) markets.

We serve a full range of customer segments, from corporate accounts, federal and local government employees and individuals to Medicare recipients and Reform enrollees, with a wide range of managed care products. We market our managed care products through both an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force.

We also offer complementary products and services, including life insurance and property and casualty insurance. As a result of our acquisition of GA Life in January 2006, we are the leading provider of life insurance policies in Puerto Rico.

In the year ended December 31, 2006, we generated total revenue of approximately $1.6 billion, of which approximately 88% was derived from our managed care businesses and 12% from our life insurance and property and casualty insurance businesses.

Industry Overview

Managed Care

The managed care industry has experienced significant changes over in the last twenty years. An increasing focus on health care costs by employers, the government and consumers has led to the growth of alternatives to traditional indemnity health insurance, such as HMOs and PPOs, which the managed care industry has introduced to attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver health care to plan members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of certain outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the medical system. In addition, providers may have incentives to achieve certain quality measures or may share medical cost risk. Members generally pay co-payments, coinsurance and deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization. An HMO plan may also require members to select one of the network primary care physicians to coordinate their care and approve any specialist or other services. The federal government provides hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons pursuant to the Medicare program, including the Medicare Advantage program. The federal government also offers prescription drug benefits to Medicare eligibles, both as part of the Medicare Advantage program and on a stand-alone basis, pursuant to Medicare Part D (also referred to as PDP stand alone product). In addition, the government of the Commonwealth of Puerto Rico (the government of Puerto Rico) provides managed care coverage to the medically indigent population of Puerto Rico through the Reform program.

Recently, economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger, more extensive health care provider networks, more member choice related to coverage, physicians and hospitals, and a desire for greater flexibility for customers to assume larger deductibles and co-payments in return for lower premiums. We believe that we are well-positioned to respond to these market preferences due to the breadth and flexibility of our product offering and size of our provider networks.

The Blue Cross Blue Shield Association (BCBSA) had 39 independent licensees as of December 31, 2006. We are licensed by BCBSA to use the "Blue Shield" name and mark throughout Puerto Rico. Most of the BCBSA licensees have the right to use the "Blue Shield" and "Blue Cross" marks in their designated geographic territories. We are not licensed to use the "Blue Cross" mark in Puerto Rico. A different BCBSA licensee has the right to use the "Blue Cross" mark in Puerto Rico. The number of people enrolled in Blue Cross Blue Shield (BCBS) plans has been steadily increasing, from 65.6 million in 1995 to 98.6 million at December 31, 2006, which represents 32.7% of the U.S. population. The BCBS plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large, multi-state employer groups. For example, all BCBS plans participate in the BlueCard program, which effectively creates a national "Blue" network. Each plan is able to take advantage of other BCBS plans' broad provider networks and negotiated provider reimbursement rates where a member covered by a policy in one state or territory lives or travels outside of the state or territory in which the policy under which he or she is covered is written. This program is referred to as BlueCard, and is a source of revenue for providing member services in Puerto Rico for individuals who are customers of other BCBS plans and at the same time provide us a significant network in the U.S. BlueCard also provides a significant competitive advantage to us because Puerto Ricans frequently travel to the continental United States.

Life Insurance

Total premiums in Puerto Rico for the life insurance market approximate $600 million. The main products in the market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are through independent agents. In recent years banks have established general agencies to sell many life products, such as term life and credit life.

Property and Casualty Insurance Segment

The total property and casualty insurance market in Puerto Rico in terms of gross premiums written for 2005 was approximately $1.8 billion. There are relatively few new sources of business in this segment, and property and casualty insurance companies compete for existing accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi peril, fire and allied lines and other general liabilities. Approximately 70% of the market is written by the top six companies in terms of market share, and approximately 80% of the market is written by companies incorporated under the laws of, and which operate principally in, Puerto Rico.

It is estimated that the Puerto Rican property and casualty insurance market has between $80 billion and $90 billion of insured value, while the industry has capital and surplus of under $1.0 billion. As a result, the market is highly dependent on reinsurance and some local carriers have diversified their operations outside of Puerto Rico, particularly to Florida.

Our Competitive Strengths

Strong Brand Recognition and Reputation in Puerto Rico. We believe that the strength of the Triple-S brand, which we have built through our longstanding presence in Puerto Rico and our exclusive license to use the Blue Shield mark, gives us a significant competitive advantage. With an operating history of over 45 years, Triple-S is the second largest locally-owned company and one of the most widely recognized brands in Puerto Rico based on several studies conducted in recent years. We have a loyal customer base with an average yearly customer retention rate of over 90% in our corporate accounts business since 2003. In addition, we believe that our participation in the Blue Cross Blue Shield Association's BlueCard PPO® program, which provides our members with coverage for medical attention throughout the United States, provides a strong competitive advantage because the primary travel destination of Puerto Rico residents is the continental United States.

Leading Market Positions with Broad Range of Managed Care Products. We are the largest managed care company in Puerto Rico according to filings with the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance). We serve approximately one million Blue Shield members across all regions of Puerto Rico and hold a leading market position covering approximately 25% of the population. We enjoy leading market positions in many customer segments, including corporate accounts, Medicare Supplement, federal government employees and individual accounts. We offer customized managed care products including health

maintenance organizations (HMOs) and preferred provider organizations (PPOs) on both a fully insured and self-funded basis to each of these customer segments, and as a result believe that we have the most comprehensive range of managed care products in Puerto Rico.

Broad Provider Networks. We believe we have the broadest geographic coverage of any managed care insurer in Puerto Rico, including hospital and physician networks consisting of some of the most well-recognized physicians and hospitals in Puerto Rico. This is important to large corporate accounts, which typically require that a single insurer cover all of their employees. For example, we believe that a number of corporate clients have contracted with us because we offer an island-wide provider network, as well as access to U.S. providers through the BlueCard program. We maintain strong provider relationships in all of our markets.

Commitment to Quality Care. We have demonstrated our commitment to quality care, implementing a number of disease management and health education programs, including programs that target asthma, diabetes, heart failure, hypertension and selected nutritional-related conditions, as well as a prenatal program and a medication therapy management program. We have had a contract with McKesson Health Solutions since 1998 pursuant to which they provide to us 24 hour nurse triage (for all of our customer sectors) and utilization management program services for the Reform segment, Medicare Advantage programs and certain commercial customers.

Strong Complementary Businesses. To enhance our relationships with managed care customers, we offer life and disability and property and casualty insurance products designed to complement the sale of our managed care products and services. As a result of our recent acquisition of GA Life, we are the leading provider of life insurance policies in Puerto Rico. Our broad range of managed care and complementary products provides us with significant opportunities to develop additional points of distribution, particularly among the insurance agencies of Puerto Rico-based financial institutions. In addition, approximately 45% of the sales agents employed by us are licensed to sell both life insurance and managed care products.

Proven and Experienced Management Team. We have been a market leader in managed care in Puerto Rico for over 45 years and believe that the extensive experience of our management team provides us with a strong competitive advantage. We also have a strong record of management continuity, which has allowed for efficiency of operations and retention of valuable knowledge. Our senior management team has an average of 13 years of experience at Triple-S.

Our Strategy

Expand Operating Margins and Realize Operating Efficiencies. Our managed care business was exempt from Puerto Rico income taxes from 1979 until 2003, and was operated as if it was a not-for-profit until that time, as required by the terms of the exemption. Accordingly, starting in 2004 we began to increase our efforts to manage medical costs and generate profits as a for-profit managed care company. Even more recently, in anticipation of becoming a public company and to compete more effectively, we have begun to implement or, in some cases, expect to implement, a number of initiatives to reduce utilization and reduce overall medical costs. Some of these initiatives include:

- re-pricing unprofitable customer contracts or permitting such contracts to lapse;
- refining our provider network;
- expanding existing Reform sector disease management programs to other sectors, such as commercial and Medicare;
- implementing radiology benefits management initiatives to reduce spending on high-tech imaging; and

- refining our pharmacy network.

We believe that increased scale in each of our segments will provide efficiencies and greater opportunities to sustain profitable growth.

Grow Medicare Advantage Business. We intend to leverage our brand recognition to further penetrate the Medicare Advantage market. We entered the Medicare Advantage market in 2005 and as of December 31, 2006 had a market share of approximately 7.0%. As of December 31, 2006, Puerto Rico had over 600,000 persons eligible for Medicare. Puerto Rico is a particularly attractive growth opportunity, as the population over the age of 65 is expected to grow at an average of 2.4% per annum between 2005 and 2010, as compared to 1.7% in the continental U.S., according to the Puerto Rico Planning Board and U.S. Census Bureau. We believe our Medicare Advantage business will continue to grow, driven by the following:

- Leveraging our position in the Reform business to expand our Medicare Advantage coverage of dual-eligibles. Approximately 31% of Medicare beneficiaries in Puerto Rico are considered dual-eligibles, persons eligible for Reform and Medicare.

- Targeting the conversion of Medicare Supplement members to the more comprehensive benefits structure offered by, and higher revenue generating, Medicare Advantage products. We introduced for the January 2007 enrollment period a variety of new Medicare Advantage products and benefits, including an integrated prescription drug plan and a commercial Medicare Advantage HMO product. In addition, we expect to grow our Medicare Advantage business through conversion of Part D members.

Develop New Products to Attract and Retain Customers. We intend to leverage our brand recognition and extensive history to drive profitable growth by introducing new products to the Puerto Rico market. Our particular focus is on the Medicare Advantage and commercial managed care segments, where we intend to introduce new products such as reduced benefits packages targeted at part-time employees, a new preferred provider network targeted at low salary industries and the uninsured, various new products for individual markets, a lower cost limited provider network and other new group products. We believe that such new products will also help us to retain existing customers by meeting their evolving needs for managed care products. We believe that Puerto Rico is a highly cost-effective market in which to introduce new products because of its dense population.

Pursue Cross-Selling and Related Opportunities. To expand our relationships with our managed care customers, we intend to capitalize on cross-selling opportunities by taking advantage of our leading brand name and using our internal and external sales forces to sell both managed care and complementary products such as life and disability and property and casualty insurance. Only 13 of our 30 largest corporate customers currently purchase both managed care and complementary products from us. We believe that our acquisition of GA Life, through which we acquired individual life insurance products and a substantial sales force, will allow us to further capitalize on cross-selling opportunities. We have established relationships with leading financial institutions in Puerto Rico which we believe will allow us to develop our business opportunities in property and casualty and life insurance products through these institutions' agency operations.

Disciplined Acquisition Strategy. We believe that profitable growth, both organic and through acquisitions, is an important part of our business. Increased scale can allow us to improve operating margins, while maintaining competitive prices for our products. We believe that we have the ability to efficiently integrate acquisitions, as evidenced by our integration of GA Life. We intend to focus on acquiring managed care plans that expand our product offering. We also may seek to expand our business outside Puerto Rico in the Caribbean or the continental United States, with a particular focus on Hispanic communities, although we currently are not able to sell our managed care products in these areas under the Blue Shield name. In addition, we believe that Puerto Rico's Reform managed care model is similar to that of many U.S. states' Medicaid programs. We may seek to leverage our expertise in the Reform business by expanding into the U.S. Medicaid managed care market via a joint venture with a U.S. managed care company or an acquisition.

Puerto Rico Economy

The economy of Puerto Rico is closely linked to that of the mainland United States, as most of the external factors that affect the Puerto Rico economy (other than the price of oil) are determined by the policies and results of the United States. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and tourist expenditures. During the fiscal year ended June 30, 2005, approximately 83% of Puerto Rico's exports went to the United States mainland, which was also the source of approximately 49% of Puerto Rico's imports. In the past, the economy of Puerto Rico has generally

followed economic trends in the overall United States economy. However, in recent years economic growth in Puerto Rico has lagged behind growth in the United States.

The dominant sectors of the Puerto Rico economy in terms of production and income are manufacturing and services. The manufacturing sector has undergone fundamental changes over the years as a result of increased emphasis on higher wage, high technology industries, such as pharmaceuticals, biotechnology, computers, microprocessors, professional and scientific instruments, and certain high technology machinery and equipment. The services sector, including finance, insurance, real estate, wholesale and retail trade, and tourism, also plays a major role in the economy. It ranks second to manufacturing in contribution to the gross domestic product and leads all sectors in providing employment.

Preliminary figures for fiscal year 2006 show that gross product increased from $45.0 billion (in current dollars) for fiscal 2002 to $56.7 billion (in current dollars) for fiscal 2006. Since fiscal 1985, personal income per capita has increased consistently each fiscal year. In fiscal 2006, personal income per capita was $12,997. Average employment increased from 1,152,000 in fiscal 2002 to 1,253,000 for fiscal 2006. Unemployment, although at relatively low historical levels, remains above the United States average. The average unemployment rate increased from 10.6% in fiscal 2005 to 11.7% in fiscal 2006. The unemployment rate for the first seven months of fiscal year 2007 was 10.3%, a decrease from 11.7% for the same period of fiscal year 2006.

Future growth in the Puerto Rico economy will depend on several factors including the condition of the United States economy, the relative stability in the price of oil imports, the exchange value of the United States dollar, the level of interest rates and changes to existing tax incentive legislation. Currently, after a number of downward revisions reflecting deterioration in several key economic indicators, the Puerto Rico Planning Board forecasts an increase in the real gross national product of 0.6% for the fiscal year ending June 30, 2007. Although updated forecasts for fiscal year 2007 are not available, key economic indicators show that the economy has been contracting since April 2006 and this trend is expected to continue until mid-2007. The major factors affecting the economy at this point are, among others, the still relatively high levels of oil prices, the depreciation of the dollar (which affects the value of imports from foreign countries, which account for approximately 50% of total imports to Puerto Rico), and the continuing economic uncertainty generated by the Puerto Rico government’s fiscal crisis.

During 2005 and 2006, the government of Puerto Rico considered several alternatives for a comprehensive tax and fiscal reform. On May 25, 2006, the Governor signed legislation providing for a fiscal reform of the Puerto Rico government, including, among other things, the reduction of government spending, the elimination or consolidation of redundant agencies and the reduction of government payroll. On July 4, 2006, the Puerto Rico legislature approved legislation providing for, among other things, a general sales and use tax of 5.5%, a municipal sales and use tax of up to 1.5%, which certain municipalities have not imposed or have imposed at a reduced rate, and certain tax relief measures to be implemented as part of the tax reform. Although the tax and fiscal reforms have been adopted, there is no assurance that such measures will generate the projected revenues or savings.

Recently, the Puerto Rico government announced a possible shortfall of budgetary funds to complete the fiscal year ending June 30, 2007 of approximately $600 million. Certain measures proposed by the governor to resolve the budgetary shortfall for fiscal year 2007 are currently being evaluated by the Puerto Rico legislature. Therefore, it is impossible for us to predict the impact that the current fiscal situation of the Puerto Rico government will have on the Puerto Rico economy and thus on our results of operations.

Products and Services

Managed Care

We offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement and Medicare Part D. Managed care products represented 88.6%, 92.7% and 92.3% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. We design our products to meet the needs and objectives of a wide range of customers, including employers, individuals and government entities. Our customers either contract

with us to assume underwriting risk or self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members' access to providers is subject to referral or preauthorization requirements.

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types of provider networks offered, the ability to use providers outside such networks and the scope of the medical management and quality assurance programs. Our members receive medical care from our networks of providers in exchange for premiums paid by the individuals or their employers and, in some instances, a cost-sharing payment between the employer and the member. We reimburse network providers according to pre-established fee arrangements and other contractual agreements.

We currently offer the following managed care plans:

Health Maintenance Organization (HMO). We offer HMO plans that provide our Reform and Medicare Advantage members with health care coverage for a fixed monthly premium in addition to applicable member co-payments. Health care services can include emergency care, inpatient hospital and physician care, outpatient medical services and supplemental services, such as dental, vision, behavioral and prescription drugs, among others. Members must select a primary care physician within the network to provide and assist in managing care, including referrals to specialists. During the third quarter of 2005, we launched Medicare Selecto, our Medicare Advantage product for dual eligibles (individuals that are eligible for both the Reform and Medicare Advantage), and in 2006 we launched a supplemental product sponsored by the government of Puerto Rico called Medicare Platino. We also recently launched our new HMO Medicare Advantage product for the non-dual eligible population.

Preferred Provider Organization (PPO). We offer PPO managed care plans that provide our commercial and Medicare Advantage members and their dependent family members with health care coverage in exchange for a fixed monthly premium from our member or the member’s employer. In addition, we provide our PPO members with access to a larger network of providers than our HMO. In contrast to our HMO product, we do not require our PPO members to select a primary care physician or to obtain a referral to utilize in-network specialists. We also provide coverage for PPO members who access providers outside of the network. Out-of-network benefits are generally subject to a higher deductible and coinsurance. In addition, we offer national in-network coverage to our PPO members through the BlueCard program. As a PPO under the Medicare Advantage program, effective January 1, 2005 we launched Medicare Optimo, our PPO Medicare Advantage policy, under which we provide extended health coverage to Medicare beneficiaries.

BlueCard. For our members who purchase our PPO and some of our Medicare Advantage products, we offer the BlueCard program. The BlueCard program offers these members in-network benefits through the networks of the other Blue Cross Blue Shield plans in the continental United States and certain U.S. territories. In addition, the BlueCard program offers our PPO members in-network coverage in over 50 countries throughout Europe and Latin America. We believe that the national and international coverage provided through this program allows us to compete effectively with large national insurers.

Medicare Supplement. We offer Medicare Supplement products, which provide supplemental coverage for many of the medical expenses that the basic Medicare program does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program’s maximum benefits.

Prescription Drug Benefit Plans. Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare

Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D pursuant to our Medicare Advantage plans as well as on a stand-alone basis. Our PDP stand-alone product, called FarmaMed, was launched in 2006. In May 2005, we launched the Drug Discount Card for local government employees and individuals. As of December 31, 2006, we had enrolled approximately 17,000 members in this program. We plan to extend the program to members in group plans without drug coverage during 2007.

Government Services. We serve as fiscal intermediary for the Medicare Part B program in Puerto Rico and the U.S. Virgin Islands, for which we receive reimbursement of all direct costs and allocated overhead expenses, based on an approved budget by the Centers for Medicare and Medicaid Services (CMS). This program is subject to change. See "Regulation - Fiscal Intermediary" included in this Item.

Administrative Services Only. In addition to our fully insured plans, we also offer our PPO products on a self-funded or ASO basis, under which we provide claims processing and other administrative services to employers. Employers choosing to purchase our products on an ASO basis fund their own claims but their employees are able to access our provider network at our negotiated discounted rates. We administer the payment of claims to the providers but we do not bear any insurance risk in connection with claims costs because we are reimbursed in full by the employer. For certain self-funded plans, we provide stop loss insurance pursuant to which we assume some of the medical risk for a premium. The administrative fee charged to self-funded groups is generally based on the size of the group and the scope of services provided.

Life Insurance

We offer a wide variety of life, accident and health and annuity products to all markets in Puerto Rico. Among these are group life and life individual insurance products. Life insurance premiums represented 5.7%, 1.2% and 1.3% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. GA Life markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases, credit and pre-need life products are marketed through independent agents. We are the only company in Puerto Rico that offers guaranteed issue, funeral and cancer policies directly to people in their homes in the lower and middle income market segments. We also market our group life coverage through our managed care subsidiary's network of exclusive agents.

Property and Casualty Insurance

We offer a wide range of property and casualty insurance products. Property and casualty insurance premiums represented 5.9%, 6.3% and 6.6% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. Our predominant lines of business are commercial multiple peril, commercial property mono-line policies, auto physical damage, auto liability and dwelling insurance. The segment's commercial lines target small to medium size accounts. We generate a majority of our dwelling business through our strong relationships with financial institutions. In the first half of 2007, we intend to expand our auto insurance business, which will write personal auto policies at discounted rates for preferred risks. During the year ended December 31, 2006, we generated our premiums in the property and casualty insurance segment primarily from the following lines of business:

Line of Business	Percentage of Total Segment Revenues for the Year Ended December 31, 2006
Commercial multi-peril line of business	42%
Dwelling and commercial property mono-line businesses	18
Auto physical damage business	14
Other	26

Reinsurance

Due to our geographical location, property and casualty insurance operations in Puerto Rico are subject to natural catastrophic activity, in particular hurricanes and earthquakes. As a result, local insurers, including us, rely on the international reinsurance market. The property and casualty insurance market has been affected by increased costs of reinsurance during the last year due to severe catastrophic losses in 2005, which are also expected to cause reinsurance costs to continue to increase in the near future.

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Over 90% of our

reinsurers have an A.M. Best rating of A- or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2006, 41.3% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insureds, we believe that the risk of our reinsurers not paying balances due to us is low.

Marketing and Distribution

Our marketing activities concentrate on promoting our strong brand, quality care, customer service efforts, size and quality of provider networks, flexibility of plan designs, financial strength and breadth of product offerings. We distribute our products through several different channels, including our salaried and commission-based internal sales force, direct mail, independent brokers and agents and telemarketing staff. We also use our website to market our products.

Branding and Marketing

Our branding and marketing efforts include "brand advertising", which focuses on the Triple-S name and the Blue Shield mark, "acquisition marketing", which focuses on attracting new customers, and "institutional advertising", which focuses on our overall corporate image. We believe that the strongest element of our brand identity is the "Triple-S" name. We seek to leverage what we believe to be the high name recognition and comfort level that many existing and potential customers associate with this brand. Acquisition marketing consists of business-to-business marketing efforts which are used to generate leads for brokers and our sales force as well as direct-to-consumer marketing which is used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe that these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the Blue Shield mark for all managed care products and services in Puerto Rico.

Distribution

Managed Care Segment. We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies and Medicare Advantage products are sold entirely through independent agents who exclusively sell our individual products, and group products are sold through our 70 person internal sales force as well as our approximately 200 independent brokers and agents. We believe that each of these marketing methods is optimally suited to address the specific needs of the customer base to which it is assigned. In the Reform sector, those notified by the government of Puerto Rico that they are eligible to participate in the Reform may enroll in the program at our branch offices.

Strong competition exists among managed care companies for brokers and agents with demonstrated ability to secure new business and maintain existing accounts. The basis of competition for the services of such brokers and agents are commission structure, support services, reputation and prior relationships, the ability to retain clients and the quality of products. We pay commissions on a monthly basis based on premiums paid. We believe that we have good relationships with our brokers and agents, and that our products, support services and commission structure are highly competitive in the marketplace.

Life Insurance Segment. In our life insurance segment, we offer our insurance products through our own network of brokers and independent agents, as well as group life insurance coverage through our managed care network of agents. We place a majority of our premiums (52% in 2006) through direct selling to customers in their homes. As of December 31, 2006, GA Life employed over 500 full-time active agents and managers and utilized approximately 570 independent agents and brokers. We pay commissions on a monthly basis based on premiums paid. In addition, GA Life has over 200 agents that are licensed to sell certain of our managed care products.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through 20 general agencies, including our insurance agency, Signature Insurance Agency, Inc. (SIA), where business is placed by independent insurance agents and brokers. SIA placed approximately 52%, 52% and 53% of total premium volume of our property and casualty insurance subsidiary, Seguros Triple-S, Inc. (STS), during the years ended December 31, 2006, 2005 and 2004, respectively. As of December 31, 2006, SIA was the third

largest insurance agency in Puerto Rico in terms of premiums written. The general agencies contracted by our property and casualty insurance subsidiary remit premiums net of their respective commission.

Customers

Managed Care

We offer our products in the managed care segment to four distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2006:

Market Sector	Enrollment at December 31, 2006	Percentage of Total Enrollment
Commercial	580,850	59.3%
Reform	357,515	36.5
Medicare Advantage	27,078	2.8
Stand-Alone Prescription Drug Plan	14,063	1.4
Total	979,506	100.0%

Commercial Sector

The commercial accounts sector includes corporate accounts, U.S. federal government employees, individual accounts, local government employees, and Medicare Supplement.

Corporate Accounts. Corporate accounts consist of small (2 to 50 employees) and large employers (over 50 employees). Employer groups may choose various funding options ranging from fully insured to self-funded financial arrangements or a combination of both. While self-funded clients participate in our managed care networks, the clients bear the claims risk, except to the extent that such self-funded clients maintain stop loss coverage, including with us.

U.S. Federal Government Employees. For more than 40 years, we have maintained our leadership in the provision of managed care to U.S. federal government employees in Puerto Rico. We provide our services to federal employees in Puerto Rico under the Federal Employees Health Benefits Program pursuant to a direct contract with the United States Office of Personnel Management (OPM). We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply with the applicable requirements for service providers. This contract is subject to termination in the event of noncompliance not corrected to the satisfaction of OPM.

Individual Accounts. We provide managed care services to individuals and their dependent family members who contract these services directly with us though our network of independent brokers. We provide individual and family contracts. We assume the risk of both medical and administrative costs in return for a monthly premium.

Local Government Employees. We provide managed care services to the local government employees of Puerto Rico through a government-sponsored program whereby we assume the risk of both medical and administrative costs for its members in return for a monthly premium. The government qualifies on an annual basis the managed care companies that participate in this program and sets the coverage, including benefits, co-payments and amount to be contributed by the government. Employees then select from one of the authorized companies and pays for the difference between the premium of the selected carrier and the amount contributed by the government.

Medicare Supplement. We offer Medicare Supplement products, which provide supplemental coverage for many of the medical expenses that the basic Medicare program does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program's maximum benefits.

Reform Sector

In 1994, the government of Puerto Rico privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into eight geographical areas and by December 31, 2001, the Reform had been fully implemented in each of these areas. Each geographical area is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2006, the Reform provided healthcare coverage to over 1.5 million people. Mental health and drug

abuse benefits are currently offered to Reform beneficiaries by behavioral healthcare companies and are therefore not part of the benefits covered by us.

The Reform program is similar to the Medicaid program, a joint federal and state health insurance program for medically indigent residents of the state. The Medicaid program is structured to provide states the flexibility to establish eligibility requirements, benefits provided, payment rates, and program administration rules, subject to general federal guidelines.

The government has adopted several measures to control the increase of Reform expenditures, which represented approximately 15.0% of total government expenditures during its fiscal year ended June 30, 2006, including closer and continuous scrutiny of participants' (members') eligibility, decreasing the number of areas in order to take advantage of economies of scale and establishing disease management programs. In addition, the government of Puerto Rico began a pilot project in 2003 in one of the eight geographical areas under which it contracted services on an ASO basis instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. All other areas that we currently serve remain with the fully-insured model; however, the government may implement such ASO program in the future. If it is adopted in any areas served by us during the contract period, we would not generate premiums in the Reform business but instead administrative service fees. On the other hand, the government has expressed its intention to evaluate different alternatives of providing health services to Reform beneficiaries.

The government of Puerto Rico has also implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as the deductibles and co-payments of prescription drug benefits. Many qualified Reform participants began moving to the government-sponsored plan in January 2006, and approximately 61,000 of such participants did so in the year ended December 31, 2006.

We provide managed care services to Reform members in the North and Southwest regions. We have participated in the Reform program since 1995. The premium rates for each Reform contract are negotiated annually. The contracts include a provision, however, that if the net income for any given contract year, as defined therein, resulting from the provision of services there under exceeds 2.5% of earned premiums, the insurance company is required to return 75.0% of the excess to the government. If the contract renewal process is not completed by a contract's expiration date, the contract may be extended by the government, upon acceptance by us, for any subsequent period of time if deemed to be in the best interests of the beneficiaries and the government. The terms of a contract, including premiums, can be renegotiated if the term of the contract is extended. Each contract is subject to termination in the event of non-compliance by the insurance company not corrected or cured to the satisfaction of the government entity overseeing the Reform, or in the event that the government determines that there is an insufficiency of funds to finance the Reform. For additional information please see "Risk Factors - We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business."

Medicare Advantage Sector

Medicare is a federal program administered by CMS that provides a variety of hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons. Medicare, with the approval of the Medicare Modernization Act, started promoting managed care organizations (MCOs), a sponsored Medicare product that offers benefits similar to or better than the traditional Medicare product, but where the risk is assumed by the MCOs. This is called Medicare Advantage. We entered into the Medicare Advantage market in 2005 and have contracts with CMS to provide extended Medicare coverage to Medicare beneficiaries under our *Medicare Optimo*, *Medicare Selecto* and *Medicare Platino* policies. Under these annual contracts, CMS pays us a set premium rate based on membership that is adjusted for demographic factors and health status. In addition, for certain of our Medicare

Advantage products the member will also pay an additional premium for additional benefits.

Stand-Alone Prescription Drug Plan Sector

Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D pursuant to our Medicare Advantage plans as well as on a stand-alone basis. Our stand-alone prescription drug plan, called *FarmaMed*, was launched in 2006.

Life Insurance

Our life insurance customers consist primarily of individuals, which hold approximately 320,000 policies, and insure approximately 1,600 groups.

Property and Casualty Insurance

Our property and casualty insurance segment targets small-to-medium sized accounts with low to average exposures to catastrophic losses. Our dwelling insurance line of business aims for rate stability and seeks accounts with a very low exposure to catastrophic losses. Our auto physical damage and auto liability customer bases consist primarily of commercial accounts.

Underwriting and Pricing

Managed Care

We strive to maintain our market leadership by providing all of our managed care members with the best health care coverage at reasonable cost. Disciplined underwriting and appropriate pricing are core strengths of our business and we believe are an important competitive advantage. We continually review our underwriting and pricing guidelines on a product-by-product and customer group-by-group basis in order to maintain competitive rates in terms of both price and scope of benefits. Pricing is based on the overall risk level and the estimated administrative expenses attributable to the particular segment. During the second quarter of 2007, we began implementing modifications to our small group underwriting process to enable us to perform a health risk assessment, based on demographics, claims experience and other variables, at the inception of the contract.

Our claims database enables us to establish rates based on our own experience and provides us with important insights about the risks in our service areas. We tightly manage the overall rating process and have processes in place to ensure that underwriting decisions are made by properly qualified personnel. In addition, we have developed and implemented a utilization review and fraud and abuse prevention program.

We have been able to maintain relatively high retention rates in the corporate accounts sector of our managed care business and since 2003 have maintained our overall market share. The retention rate in our corporate accounts, which is the percentage of existing business retained in the renewal process, has been over 90% in the last four years.

In our managed care segment, the rates are set prospectively, meaning that a fixed premium rate is determined at the beginning of each contract year and revised at renewal. We renegotiate the premiums of different groups in the corporate accounts subsector as their existing annual contracts become due. We set rates for individual contracts based on the most recent semi-annual community rating. We consider the actual claims trend of each group when determining the premium rates for the following contract year. Rates in the Reform, PDP and Medicare Advantage sectors and for federal and local government employees are set on an annual basis through negotiations with the government.

Effective January 1, 2006, payments for Medicare Advantage plans are based on a competitive bidding process that may decrease the amount of premiums paid to us or cause us to increase the benefits we offer without a corresponding

increase in premiums. As a result of the competitive bidding process, in order to maintain our current level of profitability we may in the future be required to reduce benefits or charge our members an additional premium, either of which could make our health plans less attractive to members and adversely affect our membership. For further information, see “Risk Factors — The revised rate calculation system for Medicare Advantage established by the MMA could reduce our profitability” and “Regulation — Federal Regulation — The 2003 Medicare Modernization Act — 200 Bidding Process.”

Life Insurance

Our individual life insurance business has been priced using mortality, morbidity, lapses and expense assumptions which approximate actual experience for each line of business. We review pricing assumptions on a regular basis. Individual insurance applications are reviewed by using common underwriting standards in use in the United States, and only those applications that meet these commonly used underwriting requirements are approved for policy issuance. Our group life insurance business is written on a group-by-group basis. We develop the pricing for our group life business based on mortality and morbidity experience and estimated expenses attributable to each particular line of business.

Property and Casualty Insurance

The property and casualty insurance sector has experienced soft market conditions in Puerto Rico in recent periods, principally as a result of the deregulation of commercial property rates since 2001. Notwithstanding these conditions, our property and casualty segment has maintained its leadership position in the property insurance sector by following prudent underwriting and pricing practices.

Our core business is comprised of small and medium-sized accounts. We have attained positive results through attentive risk assessment and strict adherence to underwriting guidelines, combined with maintenance of competitive rates on above-par risks designed to maintain a relatively high retention ratio. Underwriting strategies and practices are closely monitored by senior management and constantly updated based on market trends, risk assessment results and loss experience. Commercial risks in particular are fully reviewed by our professionals.

Quality Initiatives and Medical Management

We utilize a broad range of focused traditional cost containment and advanced care management processes across various product lines. We continue to enhance our management strategies, which seek to control claims costs while striving to fulfill the needs of highly informed and demanding managed care consumers. One of these strategies is the reinforcement of disease and case management programs, which empower consumers by educating them and engaging them in actively maintaining or improving their own health. Early identification of patients and inter-program referrals are the focus of these programs, which allow us to provide integrated service to our customers based on their specific conditions. The disease management programs include programs which target asthma, diabetes and selected nutrition related conditions, a prenatal program which focuses on preventing prenatal complications and promoting adequate nutrition, and a medication therapy management program aimed at plan members who are identified as having a potential for high drug usage. In addition, we have had a contract with McKesson Health Solutions since 1998 pursuant to which they provide to us a 24-hour telephone-based triage program and health information services for all our sectors. McKesson also provides utilization management and disease management program services for the Reform segment. These programs are also available in the Medicare Advantage sector and we intend to expand to the commercial sector the programs not currently offered in that sector, such as the congestive heart failure disease management program. Other strategies include innovative partnerships and business alliances with other entities to provide new products and services such as an employee assistance program and the promotion of evidence-based protocols and patient safety programs among our providers. We also employ registered nurses and social workers to manage individual cases and coordinate healthcare services. We have implemented a hospital concurrent review program, the goal of which is to monitor the appropriateness of high admission rate diagnoses and unnecessary stays. These services and programs include pre-certification and concurrent review hospital discharge services for acute patients, as well as disease management programs for the chronic care population and nurse case managers for complex population members.

In addition, we have developed and provide a variety of services and programs for the acute, chronic and complex populations. The services and programs seek to enhance quality by eliminating inappropriate hospitalizations or

services. We also encourage the usage of formulary and generic drugs, instead of non-formulary therapeutic equivalent drugs, through benefit design and member and physician interactions and have implemented a three-tier formulary which offers three co-payment levels: the lowest level for generic drugs, a higher level for brand-name drugs and the highest level for brand-name drugs that are not on the formulary. We have also established an exclusive pharmacy network with discounted rates. In addition, through arrangements with our

pharmacy benefit manager, we are able to obtain discounts and rebates on certain medications based on formulary listing and market share.

Information Systems

We have developed and implemented integrated and reliable information technology systems that we believe have been critical to our success. Our systems collect and process information centrally and support our core administrative functions, including premium billing, claims processing, utilization management, reporting, medical cost trending, as well as certain member and provider service functions, including enrollment, member eligibility verification, claims status inquiries, and referrals and authorizations.

We recently completed a system conversion process related to our property and casualty insurance business. We started the implementation of this new system in April 2005 and completed it on October 1, 2006 at an estimated cost of $4 million.

In addition, we recently selected QCSI to assess and implement new core business applications for our managed care segment. We expect the assessment to be completed in the third quarter of 2007, at which point we plan to convert our managed care system over time by line of business, with the first line of business expected to be converted in the first half of 2009. We expect the managed care conversion process to be completed by 2012 at a total cost of approximately $40 million.

These new core business applications are intended to provide functionality and flexibility to allow these entities to offer new services and products and facilitate the integration of future acquisitions. They are also designed to improve customer service, enhance claims processing and contain operational expenses.

Provider Arrangements

Approximately 98% of member services are provided through one of our contracted provider networks and the remaining 2% of member services are provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies. As of December 31, 2006, we had provider contracts with 4,285 primary care physicians, 2,992 specialists and 63 hospitals.

It is generally our philosophy not to delegate full financial responsibility to our managed care providers in the form of capitation-based reimbursement. For certain ancillary services, such as behavioral health services, and primary services in the Reform business and Medicare Optimo product, we generally enter into capitation arrangements with entities that offer broad-based services through their own contracts with providers. We attempt to provide market-based reimbursement along industry standards. We seek to ensure that providers in our networks are paid in a timely manner, and we provide means and procedures for claims adjustments and dispute resolution. We also provide a dedicated service center for our providers. We seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members.

We promote the use of electronic claims billing to our providers. Approximately 90% of claims are submitted electronically through our fully automated claims processing system, and our “first-pass rate”, or the rate at which a claim is approved for payment after the first time it is processed by our system without human intervention, for physician claims has averaged 93% for the last two years.

In the Reform sector, we have a network of Independent Practice Associations (IPAs) which provide managed care services to our Reform beneficiaries in exchange for a capitation fee. The IPA assumes the costs of certain primary care services provided and referred by its primary care physicians (PCPs), including procedures and in-patient services not related to risks assumed by us. We retain the risk associated with services provided to beneficiaries under this arrangement, such as: neonatal, obstetrical, AIDS, cancer, cardiovascular and dental services, among others.

We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the "non-hassle" factor or reduction of non-value added administrative tasks when deciding whether to contract with a managed care plan. As a result of our established position in the Puerto Rican market, the strength of the Triple-S name and our association with the BCBSA, we believe we have strong relationships with hospital and provider networks leading to a strong competitive position in terms of hospital count, number of providers and number of in-network specialists.

Hospitals. We generally contract for hospital services to be paid on an all-inclusive per diem basis, which includes all services necessary during a hospital stay. Negotiated rates vary among hospitals based on the complexity of services provided. We annually evaluate these rates and revise them, if appropriate.

Physicians. Fee-for-service is our predominant reimbursement methodology for physicians, except for the Reform sector. Our physician rate schedules applicable to services provided by in-network physicians are pegged to a resource-based relative value system fee schedule and then adjusted for competitive rates in the market. This structure is similar to reimbursement methodologies developed and used by the federal Medicare system and other major payers. Payments to physicians under the Medicare Advantage program are based on Medicare fees. In the Reform sector, we make payments to certain of our providers in the form of capitation-based reimbursement.

Services are provided to our members through our network providers with whom we contract directly. Members seeking medical treatment outside of Puerto Rico are served by providers in these areas through the BlueCard program, a third-party national provider network.

Subcontracting. We subcontract our triage call center, utilization management and disease management, mental and substance abuse health services for federal government employees and other large ASO accounts, and pharmacy benefits management services through contracts with third parties.

In addition, we contract with a number of other ancillary service providers, including laboratory service providers, home health agency providers and intermediate and long-term care providers, to provide access to a wide range of services. These providers are normally paid on either a fee schedule or fixed per day or per case basis.

Competition

The insurance industry in Puerto Rico is highly competitive and is comprised of both local and foreign entities. The approval of the Gramm-Leach-Bliley Act of 1999, which applies to financial institutions domiciled in Puerto Rico, has opened the insurance market to new competition by allowing financial institutions such as banks to enter into the insurance business. At the moment, several banks in Puerto Rico have established subsidiaries that operate as insurance agencies.

Managed Care

The managed care industry is highly competitive, both nationally and in Puerto Rico. Competition continues to be intense due to aggressive marketing, business consolidations, a proliferation of new products and increased quality awareness and price sensitivity among customers. Industry participants compete for customers based on the ability to provide a total value proposition which we believe includes quality of service and flexibility of benefit designs, access to and quality of provider networks, brand recognition and reputation, price and financial stability.

We believe that our competitive strengths, including our leading presence in Puerto Rico, our Blue Shield license, the size and quality of our provider network, the broad range of our product offerings, our strong complementary businesses and our experienced management team, position us well to satisfy these competitive requirements.

Competitors in the managed care segment include national and local managed care plans. We currently have approximately 980,000 members enrolled in our managed care segment at December 31, 2006, representing approximately 25% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 25% for the year ended December 31, 2006. We offer a variety of managed care products, and are the leader by market share in almost every sector, as measured by the share of premiums written. Our nearest competitor is Medical Card Systems Inc., which had a market share of approximately 17% for the year ended

December 31, 2006. Our other largest competitors in the managed care segment are Aveta Inc. (or MMM Healthcare) and Humana Inc.

Life Insurance

As a result of the GA Life acquisition, we are the leading provider of life insurance products in Puerto Rico. In the life insurance segment, we are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines, in particular from Cooperativa de Seguros de Vida de Puerto Rico and National Life Insurance Company. In the ordinary life sector, our main competitors are National Life Insurance Company and Americo Financial Life and Annuity Insurance Company. In group life insurance, our main competitors are Hartford Life, Inc., Universal Life Insurance Company and Metropolitan Life Insurance Company. In the cancer sector, our main competitors are National Life Insurance Company, Trans-Oceanic Life Insurance Company, Universal Life Insurance Company and American Family Insurance.

Property & Casualty Insurance

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions prevailed during 2006 in Puerto Rico. In the local market, such conditions mostly affected commercial risks, precluding rate increases and even provoking lower premiums on both renewals and new business. Property and casualty insurance companies tend to compete for the same accounts through more favorable price and/or policy terms and better quality of services. We compete by reasonably pricing our products and providing efficient services to producers, agents and clients. We believe that our knowledgeable, experienced personnel are also an incentive for our customers to conduct business with us.

In 2006, we ranked among the top five largest companies in the property and casualty insurance market in Puerto Rico, as measured by direct premiums, with a market share of approximately 8.5%. Our nearest competitors in the property and casualty insurance market in Puerto Rico in 2006 were National Insurance Company and Integrand Assurance Company. The market leaders in the property and casualty insurance market in Puerto Rico in 2006 were Universal Insurance Group, Cooperativa de Seguros Múltiples de Puerto Rico and MAPFRE Corporation.

Blue Shield License

We have the exclusive right to use the Blue Shield name and mark for the sale, marketing and administration of managed care plans and related services in Puerto Rico. We believe that the Blue Shield name and mark are valuable brands of our products and services in the marketplace. The license agreements, which have a perpetual term (but which are subject to termination under circumstances described below), contain certain requirements and restrictions regarding our operations and our use of the Blue Shield name and mark.

Upon the occurrence of any event causing the termination of our license agreements, we would cease to have the right to use the Blue Shield name and mark in Puerto Rico. We also would no longer have access to the BCBSA networks of providers and BlueCard Program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of a significant fee to the BCBSA. Furthermore, if our licenses were terminated, the BCBSA would be free to issue a new license to use the Blue Shield name and marks in Puerto Rico to another entity, which would have a material adverse affect on our business, financial condition and results of operations. See “Risk Factors - The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations.”

Events which could result in termination of our license agreements include, but are not limited to:

- failure to maintain our total adjusted capital at 200% of Health Risk-Based Capital Authorized Control Level, as defined by the National Association of Insurance Commissioners (NAIC) Risk Based Capital (RBC) model act;

- failure to maintain liquidity of greater than one month of underwritten claims and administrative expenses, as defined by the BCBSA, for two consecutive quarters;

- failure to satisfy state-mandated statutory net worth requirements;
- impending financial insolvency; and
- a change of control not otherwise approved by the BCBSA or a violation of the BCBSA voting and ownership limitations on our capital stock.

The BCBSA license agreements and membership standards specifically permit a licensee to operate as a for-profit, publicly-traded stock company, subject to certain governance and ownership requirements.

Pursuant to our license agreements with BCBSA, at least 80% of the revenue that we earn from health care services in Puerto Rico, and at least 66.7% of the revenue that we earn from (or at least 66.7% of the enrollment for) health care services both in the United States and in Puerto Rico together, must be sold, marketed, administered, or underwritten through use of the Blue Shield name and mark. This may limit the extent to which we will be able to expand our health care operations, whether through acquisitions of existing managed care providers or otherwise, in areas where a holder of an exclusive right to the Blue Shield name and mark is already present. Currently, the Blue Shield name and mark is exclusively licensed to other entities in all markets in the continental United States, Hawaii, and Alaska.

Pursuant to the rules and license standards of the BCBSA, we guarantee our subsidiaries' contractual and financial obligations to their respective customers. In addition, pursuant to the rules and license standards of the BCBSA, we have agreed to indemnify the BCBSA against any claims asserted against it resulting from our contractual and financial obligations.

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the Blue Shield name and mark. During the years ended December 31, 2006 and, 2005, we paid fees to the BCBSA in the amount of $964,956 and $791,587, respectively. The BCBSA is a national trade association of 39 Blue Cross Blue Shield licensees (also known as "Member Plans"), the primary function of which is to promote and preserve the integrity of the Blue Cross Blue Shield names and marks, as well as to provide certain coordination among the Member Plans. Each Blue Cross Blue Shield Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the Blue Shield names and marks outside our Blue Shield licensed territory.

We do not have the authority to use the Blue Cross name and marks in Puerto Rico.

BlueCard. Under the rules and license standards of the BCBSA, other Blue Cross Blue Shield Plans must make available their provider networks to members of the BlueCard Program in a manner and scope as consistent as possible to what such member would be entitled to in his or her home region. Specifically, the Host Plan (located where the member receives the service) must pass on discounts to BlueCard members from other Plans that are at least as great as the discounts that the providers give to the Host Plan's local members. The BCBSA requires us to pay fees to any Host Blue Cross Blue Shield Plan whose providers submit claims for health care services rendered to our members who receive care in their service area. Similarly, we are paid fees for submitting claims and providing other services to members of other Blue Cross Blue Shield Plans who receive care in our service area.

Claim Liabilities

We are required to estimate the ultimate amount of claims which have not been reported, or which have been received but not yet adjudicated, during any accounting period. These estimates, referred to as claim liabilities, are recorded as liabilities on our balance sheet.

We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. For additional information regarding the calculation of claim liabilities, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies and Estimates — Claim Liabilities.”

Investments

Our investment philosophy is to maintain a largely investment-grade fixed income portfolio, provide adequate liquidity for expected liability durations and other requirements, and maximize total return through active investment management.

We evaluate the interest rate risk of our assets and liabilities regularly, as well as the appropriateness of investments relative to our internal investment guidelines. We operate within these guidelines by maintaining a diversified portfolio, both across and within asset classes.

Investment decisions are centrally managed by investment professionals based on the guidelines established by management and approved by our finance committee. Our internal investment group is comprised of the CFO, an investment officer, a cash management officer and a treasury operations officer. The internal investment group uses an external investment consultant and manages our short-term investments, fixed income portfolio and equity securities of Puerto Rican corporations that are classified as available for sale. In addition, we use GE Asset Management, Lord Abbett and State Street Global Advisor as portfolio managers for our trading securities.

We have a finance committee, composed of members of the board of directors, which monitors and approves investment policies and procedures. The investment portfolio is managed following those policies and procedures, and any exception must be reported to our finance committee.

For additional information on our investments, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations — Quantitative and Qualitative Disclosures About Market Risk — Market Risk Exposure.”

Trademarks

We consider our trademarks of “Triple-S” and “SSS” very important and material to all segments in which it is engaged. In addition to these, other trademarks used by our subsidiaries that are considered important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the “Blue Shield” mark in Puerto Rico. See “— Blue Shield License.”

Employees

As of March 31, 2007, we had 2,266 full-time employees and 273 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 45% of our managed care subsidiary’s 794 regular employees. The collective bargaining agreement expires on July 31, 2012. We consider our relations with employees to be good.

Properties

We own a seven story (including the basement floor) building located at 1441 F.D. Roosevelt Avenue, in San Juan, Puerto Rico, and two adjacent buildings, as well as the adjoining parking lot. In addition, we own five floors of a fifteen-story building located at 1510 F.D. Roosevelt Avenue, in Guaynabo, Puerto Rico. The properties are subject to liens under our credit facilities. See “Management’s Discussion and Analysis of Financial Condition and Results of Operation — Liquidity and Capital Resources.”

In addition to the properties described above, we or our subsidiaries are parties to operating leases that are entered into in the ordinary course of business.

We believe that our facilities are in good condition and that the facilities, together with capital improvements and additions currently underway, are adequate to meet our operating needs for the foreseeable future. The need for expansion, upgrading and refurbishment of facilities is continually evaluated in order to keep facilities aligned with planned business growth and corporate strategy.

History and Corporate Information

We have been owned since our inception in 1959 by doctors and dentists that are or were providers in our managed care networks. We were incorporated under the laws of Puerto Rico in January 1999 as part of a reorganization pursuant to which our current holding company structure was created. The purpose of the reorganization was to increase our flexibility, as holding companies are not insurance companies within the meaning of the Puerto Rico Insurance Code and are therefore generally not subject to the limitations applicable to insurance companies. Pursuant to the reorganization, shares of our predecessor managed care company Seguros de Servicios de Salud de Puerto Rico, Inc. (SSS) were exchanged for shares of a newly-created holding company, Triple-S Management Corporation (TSM), and SSS transferred the ownership of its wholly-owned subsidiaries and sold all of its real estate holdings to TSM. SSS was merged into Triple-S Salud, Inc., which subsequently changed its name to Triple-S, Inc. (TSI), our managed care subsidiary.

In order to enhance our product offering, in the 1980s we commenced property and casualty insurance operations through the establishment of our subsidiary Seguros de Vida Triple-S (STS) and life insurance operations through the establishment of our former subsidiary Seguros de Vida Triple-S, which was merged into GA Life in June 2006. These lines of business have grown to become significant market participants in Puerto Rico.

From 1979 until 2002, our managed care subsidiary and its predecessor companies were exempt from Puerto Rico income taxes pursuant to a ruling issued by the Department of the Treasury of Puerto Rico (the Department of Treasury). On July 31, 2003, we and our managed care subsidiary executed a closing agreement with the Department of Treasury which terminated our managed care subsidiary's tax exemption effective December 31, 2002. Accordingly, effective January 1, 2003 our managed care subsidiary became subject to Puerto Rico income taxes. The termination was the result of a new public policy of the Department of Treasury which provided that entities organized as for-profit corporations, such as our managed care subsidiary, were no longer entitled to the tax exemptions under the Puerto Rico tax code.

Pursuant to the closing agreement, we agreed to pay taxes in respect of our managed care subsidiary's accumulated statutory net income since 1979.

The tax exemption ruling contained a prohibition on declaring dividends. Accordingly, until December 31, 2002, the amount of our net income available for distribution to shareholders had excluded amounts derived from our managed care subsidiary's results of operations. Following the termination of the tax exemption effective December 31, 2002, the earnings of our managed care subsidiary became available for distribution to our shareholders and in 2007 and 2006, the board declared and paid a cash dividend in the aggregate amount of $2.5 and $6.2 million, respectively. Prior to the January 2006 dividend, we had not declared or distributed any dividends on our common stock since our inception in 1959.

History of Puerto Rico

Puerto Rico, the fourth largest of the Caribbean islands, is located approximately 1,600 miles southeast of New York. The population of Puerto Rico was approximately 3.9 million in 2005, as estimated by the U.S. Census Bureau. The San Juan metropolitan area, Puerto Rico's principal economic hub which includes the municipalities surrounding San Juan, had a population of approximately 1.5 million in 2005.

Puerto Rico came under United States sovereignty pursuant to the Treaty of Paris in 1898. Puerto Ricans have been citizens of the United States since 1917. The United States and Puerto Rico share a common defense, market, and currency. Puerto Rico exercises virtually the same control over its internal affairs as do the 50 states. It differs from the states, however, in its relationship with the federal government. The people of Puerto Rico are citizens of the United States but do not vote in national elections. They are represented in Congress by a Resident Commissioner

who has a voice in the House of Representatives but no vote. Most federal taxes, except those such as Social Security taxes which are imposed by mutual consent, are not levied in Puerto Rico. No federal income tax is collected from Puerto Rico residents on income earned in Puerto Rico, except for certain federal government employees who are subject to taxes on their salaries.

The Constitution of Puerto Rico provides for the separation of powers of the executive, legislative, and judicial branches of government. The Governor is elected every four years. The Legislative Assembly consists of a Senate and a House of Representatives, the members of which are elected for four-year terms. The highest court within the local jurisdiction is the Supreme Court of Puerto Rico. Puerto Rico constitutes a District in the Federal Judiciary and has its own United States District Court. Decisions of this court may be appealed to the United States Court of Appeals for the First Circuit and from there to the Supreme Court of the United States.

Legal Proceedings

Various litigation claims and assessments against us have arisen in the ordinary course of business, including but not limited to, our activities as an insurer and employer. Furthermore, the Commissioner of Insurance, as well other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations.

Management believes, based on the opinion of legal counsel, that the aggregate liabilities, if any, arising from such claims, assessments, audits and lawsuits would not have a material adverse effect on our consolidated financial position or results of operations. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could, have a material adverse effect on our operating results and/or cash flows.

Additionally, we may face various potential litigation claims that have not to date been asserted, including claims from persons purporting to have contractual rights to acquire shares of the Corporation on favorable terms or to have inherited such shares notwithstanding applicable transfer and ownership restrictions. See “Risk Factors — Risks Relating to our Capital Stock.”

Sánchez Litigation

On September 4, 2003, José Sánchez and others filed a putative class action complaint against us, present and former directors of the board of directors and our managed care subsidiary, and others, in the United States District Court for the District of Puerto Rico, alleging violations under the Racketeer Influenced and Corrupt Organizations Act (RICO). Among other allegations, the suit alleges a scheme to defraud the plaintiffs by acquiring control of our managed care subsidiary through illegally capitalizing our managed care subsidiary and later converting it to a for profit corporation and depriving the shareholders of their ownership rights. The plaintiffs base their allegations on the alleged decisions of our managed care subsidiary’s board of directors and shareholders, purportedly made in 1979, to operate with certain restrictions in order to turn our managed care subsidiary into a charitable corporation. On May 4, 2006, the Court issued an Opinion and Order awarding summary judgment in favor of all the defendants, thereby dismissing the case. Plaintiffs filed a notice of appeal before the United States Court of Appeals for the First Circuit. The Appeals Court notified the briefing schedule, and plaintiffs filed their brief on August 21, 2006. Defendants filed their appellate briefs on September 30, 2006. The parties argued the case before the First Circuit on February 6, 2007, which took the case under advisement and was expected to issue a judgment within approximately 90 days of such date.

Jordán et al Litigation

On April 24, 2002, Octavio Jordán, Agripino Lugo, Ramón Vidal, and others filed a suit against TSM, TSI and others in the Court of First Instance for San Juan, Superior Section, alleging, among other things, violations by the defendants of provisions of the Puerto Rico Insurance Code, antitrust violations, unfair business practices and damages in the amount of $12.0 million. They also requested that we sell shares to them. We believe that many of the allegations brought by the plaintiffs in this complaint have been resolved in favor of us and our managed care subsidiary in previous cases brought by the same plaintiffs in the United States District Court for the District of Puerto Rico and in the local courts. The defendants, including us and our managed care subsidiary, answered the complaint,

filed a counterclaim and filed several motions to dismiss.

On May 9, 2005, the plaintiffs amended the complaint to allege causes of action similar to those dismissed in the Sánchez case. Defendants moved to dismiss all claims in the amended complaint. Plaintiffs opposed the motions to dismiss and defendants filed corresponding replies. In 2006, the Court held several hearings concerning these dispositive motions and stayed all discovery until the motions were resolved.

On January 19, 2007, the Court denied a motion by the plaintiffs to dismiss the defendants' counterclaim for malicious prosecution and abuse of process. The Court ordered plaintiffs to answer the counterclaim by February 20, 2007. Although they filed after the required date, plaintiffs have filed an answer to the counterclaim.

On February 7, 2007, the Court dismissed all of the charitable trust, RICO and violation of due process claims, and most of the tort, breach of contract and violation of the Puerto Rico corporations' law claims, but allowed the antitrust claims to proceed. We have appealed the denial of the motion to dismiss as to the antitrust claims to the Puerto Rico Court of Appeals.

Thomas Litigation

On May 22, 2003, a putative class action suit was filed by Kenneth A. Thomas, M.D. and Michael Kutell, M.D., on behalf of themselves and all others similarly situated and the Connecticut State Medical Society against BCBSA and substantially all of the other Blue plans in the United States, including our managed care subsidiary. The case is pending before the U.S. District Court for the Southern District of Florida, Miami District.

The individual plaintiffs bring this action on behalf of themselves and a class of similarly situated physicians seeking redress for alleged illegal acts of the defendants, which they allege have resulted in a loss of their property and a detriment to their business, and for declaratory and injunctive relief to end those practices and prevent further losses. Plaintiffs alleged that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to doctors so that they are not paid in a timely manner for the covered, medically necessary services they render.

The class action complaint alleges that the health care plans are the agents of BCBSA licensed entities, and as such have committed the acts alleged above and acted within the scope of their agency, with the consent, permission, authorization and knowledge of the others, and in furtherance of both their interest and the interests of other defendants.

Management believes that our managed care subsidiary was brought to this litigation for the sole reason of being associated with the BCBSA. However, on June 18, 2004 the plaintiffs moved to amend the complaint to include the Colegio de Médicos y Cirujanos de Puerto Rico (a compulsory association grouping all physicians in Puerto Rico), Marissel Velázquez, MD, President of the Colegio de Médicos y Cirujanos de Puerto Rico, and Andrés Meléndez, MD, as plaintiffs against our managed care subsidiary. Later Marissel Velázquez, MD voluntarily dismissed her complaint against our managed care subsidiary.

Our managed care subsidiary, along with the other defendants, moved to dismiss the complaint on multiple grounds, including but not limited to arbitration and applicability of the McCarran Ferguson Act.

The parties are currently engaged in mediation. Twenty four plans have been actively participating in the mediation efforts. The mediation resulted in the creation of a Settlement Agreement, presently under discussion with the plaintiffs' lawyers.

REGULATION

The operations of our managed care business are subject to comprehensive and detailed regulation in Puerto Rico, as well as U.S. Federal regulation. Supervisory agencies include the Commissioner of Insurance, the Health Department of the Commonwealth of Puerto Rico and the Administration for Health Insurance of the Commonwealth of Puerto Rico (ASES, for its Spanish acronym), which administers the Reform Program for the Commonwealth of Puerto Rico. Federal regulatory agencies that oversee our operations include CMS, the Office of the Inspector General of the U.S. Department of Health and Human Services, the Office for Civil Rights, the U.S. Department of Justice, and the Office of Personnel Management. These government agencies have the right to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of the products and services we offer;
- assess fines, penalties and/or sanctions;
- monitor our solvency and adequacy of our financial reserves; and
- regulate our investment activities on the basis of quality, diversification and other quantitative criteria, within the parameters of a list of permitted investments set forth in applicable insurance laws and regulations.

Our operations and accounts are subject to examination and audits at regular intervals by these agencies. In addition, the U.S. Federal and local governments continue to consider and enact many legislative and regulatory proposals that have impacted, or would materially impact, various aspects of the health care system. Some of the more significant current issues that may affect our managed care business include:

- initiatives to increase healthcare regulation, including efforts to expand the tort liability of health plans;
- local government plans and initiatives;
- Reform and Medicare reform legislation; and
- increased government concerns regarding fraud and abuse.

The U.S. Congress is continuing to develop legislation efforts directed toward patient protection, including proposed laws that could expose insurance companies to economic damages, and in some cases punitive damages, for making a determination denying benefits or for delaying members' receipt of benefits as well as for other coverage determinations. Similar legislation has been proposed in Puerto Rico. Given the political process, it is not possible to determine whether any federal and/or local legislation or regulation will be enacted in 2007 or what form any such legislation might take. Other legislative or regulatory changes that may affect us are described below. While certain of these measures could adversely affect us, at this time we cannot predict the extent of this impact.

The Federal government and the government of Puerto Rico, including the Commissioner of Insurance, have adopted laws and regulations that govern our business activities in various ways. These laws and regulations may restrict how we conduct our business and may result in additional burdens and costs to us. Areas of governmental regulation include:

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- transactions resulting in a change of control;
- member rights and responsibilities;
- fraud and abuse;

· underwriting rules and procedures;
· benefit mandates;
· eligibility requirements;
· sales and marketing activities;
· quality assurance procedures;
· privacy of medical and other information and permitted disclosures;

· security of electronically transmitted individually identifiable health information;
· geographic service areas;
· market conduct;
· utilization review;
· payment of claims, including timeliness and accuracy of payment;
· special rules in contracts to administer government programs;
· transactions with affiliated entities;
· limitations on the ability to pay dividends;
· rates of payment to providers of care;
· rates of payment to providers of care;
· surcharges on payments to providers;
· provider contract forms;
· delegation of financial risk and other financial arrangements in rates paid to providers of care;
· agent licensing;
· financial condition (including reserves);
· reinsurance;
· issuance of new shares of capital stock;
· corporate governance; and
· permissible investments.

These laws and regulations are subject to amendments and changing interpretations in each jurisdiction. Failure to comply with existing or future laws and regulations could materially and adversely affect our operations, financial condition and prospects.

Puerto Rico Insurance Laws

Our insurance subsidiaries are subject to the regulations and supervision of the Commissioner of Insurance. The regulations and supervision of the Commissioner of Insurance consist primarily of the approval of certain policy forms, the standards of solvency that must be met and maintained by insurers and their agents, and the nature of and limitations on investments, deposits of securities for the benefit of policyholders, methods of accounting, periodic examinations and the form and content of reports of financial condition required to be filed, among others. In general, such regulations are for the protection of policyholders rather than security holders.

Puerto Rico insurance laws prohibit any person from offering to purchase or sell voting stock of an insurance company with capital contributed by shareholders (a stock insurer) which constitutes 10% or more of the total issued and outstanding stock of such company or of the total issued and outstanding stock of a company that controls an insurance company, without the prior approval of the Commissioner of Insurance. The proposed purchaser or seller must disclose any changes proposed to be made to the administration of the insurance company and provide the Commissioner of Insurance with any information reasonably requested. The Commissioner of Insurance must make a determination within 30 days of the later of receipt of the petition or of additional information requested. The determination of the Commissioner of Insurance will be based on its evaluation of the transaction's effect on the public, having regard to the experience and moral and financial responsibility of the proposed purchaser, whether such responsibility of the proposed purchaser will affect the effectiveness of the insurance company's operations and whether the change of control could jeopardize the interests of insureds, claimants or the company's other shareholders. Our articles prohibit any institutional investor from owning 10% or more of our voting power, any person that is not an institutional investor from owning 5% or more of our voting power, and any person from beneficially owning shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest in us. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles.

Puerto Rico insurance laws also require that stock insurers obtain the Commissioner of Insurance's approval prior to any merger or consolidation. The Commissioner of Insurance cannot approve any such transaction unless it determines that such transaction is just, equitable, consistent with the law and no reasonable objection exists. The merger or consolidation must then be authorized by a duly approved resolution of the board of directors and ratified by the affirmative vote of two-thirds of all issued and outstanding shares of capital stock with the right to vote thereon.

The reinsurance of all or substantially all of the insurance of an insurance company by another insurance company is also deemed to be a merger or consolidation.

Puerto Rico insurance laws further prohibit insurance companies and insurance holding companies, among other entities, from soliciting or receiving funds in exchange for any new issuance of its securities, other than

through a stock dividend, unless the Commissioner of Insurance has granted a solicitation permit in respect of such transaction. The Commissioner of Insurance will issue the permit unless it finds that the funds proposed to be secured are excessive for the purpose intended, the proposed securities and their distribution would be inequitable, or the issuance of the securities would jeopardize the interests of policyholders or securityholders.

Puerto Rico insurance laws also limit insurance companies' ability to reinsure risk. Insurance companies can only accept reinsurance in respect of the types of insurance which they are authorized to transact directly. Also, except for life insurance, insurance companies cannot accept any reinsurance in respect of any risk resident, located, or to be performed in Puerto Rico which was insured as direct insurance by an insurance company not then authorized to transact such insurance in Puerto Rico. As a result, insurance companies can only reinsure their risks with insurance companies in Puerto Rico authorized to transact the same type of insurance or with a foreign insurance company that has been approved by the Commissioner of Insurance. Insurance companies cannot reinsure 75% or more of their direct risk with respect to any type of insurance without first obtaining the approval of the Commissioner of Insurance.

Privacy of Financial and Health Information

Puerto Rico law requires that managed care providers maintain the confidentiality of financial and health information. The Commissioner of Insurance has promulgated regulations relating to the privacy of financial information and individually identifiable health information. Managed care providers must periodically inform their clients of their privacy policies and allow such clients to opt-out if they do not want their financial information to be shared. However, the regulations related to the privacy of health information do not apply to managed care providers, such as us, who comply with the provisions of HIPAA. Also, Puerto Rico law requires that managed care providers provide patients with access to their health information within a specified time and that they not charge more than a predetermined amount for such access. The law imposes various sanctions on managed care providers that fail to comply with these provisions.

Managed Care Provider Services

Puerto Rico law requires that managed care providers cover and provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialized services. In addition, the Office of the Solicitor for the Beneficiaries of the Reform is authorized to review and supervise the operations of entities contracted by the Commonwealth of Puerto Rico to provide services under the Reform. The Solicitor may investigate and adjudicate claims filed by beneficiaries of the Reform against the various service providers contracted by the Commonwealth of Puerto Rico. See "Business—Customers—Medicare Supplement—Reform Sector" for mor information.

Capital and Reserve Requirements

In addition to the capital and reserve requirements set forth below, the Commissioner of Insurance requires our managed care subsidiary to maintain minimum capital of $1.0 million, our life insurance subsidiary to maintain minimum capital of $2.5 million and our property and casualty insurance subsidiary to maintain minimum capital of $3.0 million. In addition, our managed care subsidiary is subject to the capital and surplus licensure requirements of the BCBSA.

The capital and surplus requirement of the BCBSA are based on the National Association of Insurance Commissioners' (NAIC) RBC Model Act. These capital and surplus requirements are intended to assess the capital adequacy of life and accident and health insurers, taking into account the risk characteristics of an insurer's investments and products. The RBC Model Act set forth the formula for calculating the risk-based capital requirements, which are designed to take into account risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business.

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company's risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four

different levels of regulatory attention depending on the ratio of the company's total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The "company action level" is triggered if a company's total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its risk-based capital is subject to a trend test. The trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company's adjusted capital exceeds it risk-based capital) between the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190%, then company action level regulatory action will occur.

The "regulatory action level" is triggered if a company's total adjusted capital is less than 150% but greater than or equal to 100% of its risk-based capital. At the regulatory action level, the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The "authorized control level" is triggered if a company's total adjusted capital is less than 100% but greater than or equal to 70% of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including placing the company under regulatory control. The "mandatory control level" is triggered if a company's total adjusted capital is less than 70% of its risk-based capital, at which level the regulatory authority must place the company under its control.

We and our insurance subsidiaries currently meet the minimum capital requirements of the Commissioner of Insurance and the BCBSA, as applicable. Regulation of financial reserves for insurance companies and their holding companies is a frequent topic of legislative and regulatory scrutiny and proposals for change. It is possible that the method of measuring the adequacy of our financial reserves could change and that could affect our financial condition.

Natural disasters have affected Puerto Rico greatly over the past 10 years and have prompted the local government to mandate property and casualty insurance reserves. In addition to its catastrophic reinsurance coverage, we are required by local regulatory authorities to establish and maintain a trust fund (the Trust) to protect us from our dual exposure to hurricanes and earthquakes. The Trust is intended to be used as our first layer of catastrophe protection whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust are determined by a rate (1% in 2006 and 2005), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2006 and 2005, we had $27.1 million and $25.1 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance. For additional details see note 19 of the audited consolidated financial statements.

Dividend Restrictions

Puerto Rico insurance laws also restrict insurance companies' ability to pay dividends, as they provide that such companies can only pay cash dividends from their available surplus funds derived from realized net profits and cannot pay dividends with funds derived from loans. Any violation of these provisions would subject us to a penalty under these laws.

Puerto Rico insurance laws are not directly applicable to us, as a holding company, since we are not an insurance company. However, we, together with our insurance subsidiaries, are subject to the provisions of the General Corporation Law of Puerto Rico (PRGCL), which contains certain restrictions on the declaration and payment of dividends by corporations organized pursuant to the laws of Puerto Rico. These provisions provide that Puerto Rico corporations may only declare dividends charged to their surplus or, in the absence of such surplus, net profits of the fiscal year in which the dividend is declared and/or the preceding fiscal year. The PRGCL also contains provisions

regarding the declaration and payment of dividends and directors' liability for illegal payments.

Guaranty Fund Assessments

We are required by Puerto Rico law and by the BCBSA guidelines to participate in certain guarantee associations. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Other Contingencies — Guarantee Association" for additional information.

Federal Regulation

The Medicare Program and Medicare Advantage

Medicare is the health insurance program for retired United States citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by CMS.

The Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a $131 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as "Medigap", to cover deductibles, co-payments, and coinsurance.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician and use the services of any hospital, healthcare provider, or facility certified by Medicare. CMS reimburses providers if Medicare covers the service and CMS considers it "medically necessary." There is currently no fee-for-service coverage for certain preventive services, including annual physicals and well visits, eyeglasses, hearing aids, dentures and most dental services.

As an alternative to the traditional fee-for-service Medicare program, in geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created a Medicare Part C, formerly known as Medicare+Choice and now known as Medicare Advantage. Pursuant to Medicare Part C, Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly premium payment per member from CMS. The monthly premium varies based on the county in which the member resides, as adjusted to reflect the member's demographics and the plans' risk scores. Individuals who elect to participate in the Medicare Advantage program often receive greater benefits than traditional fee-for-service Medicare beneficiaries including, in some Medicare Advantage plans including ours, additional preventive services, and dental and vision benefits. Medicare Advantage plans typically have lower deductibles and co-payments than traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies. In exchange for these enhanced benefits, members are generally required to use only the services and provider network provided by the Medicare Advantage plan. Most Medicare Advantage plans have no additional premiums. In some geographic areas, however, and for plans with open access to providers, members may be required to pay a monthly premium.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans' members. One of CMS's primary directives in establishing the Medicare+Choice

program was to make it more attractive to managed care plans to enroll members with higher intensity illnesses. To accomplish this, CMS implemented a risk adjustment payment system for Medicare health plans pursuant to the Balanced Budget Act of 1997 (BBA). This payment system was further modified pursuant to the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CMS is phasing in this risk adjustment payment methodology with a model that bases a portion of the total CMS reimbursement payments on

various clinical and demographic factors including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS's internal database. Under this system, the risk adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan's average gender, age, and disability demographics. During 2003, risk adjusted payments accounted for only 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional demographic rate book. The portion of risk adjusted payments was increased to 30% in 2004, 50%, in 2005 and 75% in 2006, and has increased to 100% in 2007.

The 2003 Medicare Modernization Act

Overview. In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act (MMA). The MMA increased the amounts payable to Medicare Advantage plans such as ours, expanded Medicare beneficiary healthcare options by, among other things, creating a transitional temporary prescription drug discount card program for 2004 and 2005 and added a Medicare Part D prescription drug benefit beginning in 2006, as further described below.

One of the goals of the MMA was to reduce the costs of the Medicare program by increasing participation in the Medicare Advantage program. Effective January 1, 2004, the MMA adjusted Medicare Advantage statutory payment rates to 100% of Medicare's expected cost per beneficiary under the traditional fee-for-service program. Generally, this adjustment resulted in an increase in payments per member to Medicare Advantage plans. Medicare Advantage plans are required to use these increased payments to improve the healthcare benefits that are offered, to reduce premiums or to strengthen provider networks. The reforms proposed by the MMA, including in particular the increased reimbursement rates to Medicare Advantage plans, have allowed and will continue to allow Medicare Advantage plans to offer more comprehensive and attractive benefits, including better preventive care and dental and vision benefits, while also reducing out-of-pocket expenses for beneficiaries.

Prescription Drug Benefit. As part of the MMA, every Medicare recipient is able to select a prescription drug plan through Medicare Part D. Medicare Part D replaced the Medicaid Prescription Drug Coverage for beneficiaries eligible for participation under both the Medicare and Medicaid programs, or dual-eligibles. The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs, as described below. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for member demographics and risk factor payments. The beneficiary will be responsible for the difference between the government subsidy and his or her plan's bid, together with the amount of his or her plan's supplemental premium (before rebate allocations), subject to the co-pays, deductibles and late enrollment penalties, if applicable, described below. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit (MA-PD) while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan (PDP) from a list of CMS-approved PDPs available in their area. Any Medicare Advantage Member enrolling in a stand-alone PDP, however, will automatically be disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare. Under the standard Part D drug coverage for 2006, beneficiaries enrolled in a stand-alone PDP will pay a $250 deductible, co-insurance payments equal to 25% of the drug costs between $250 and the initial annual coverage limit of $2,250 and all drug costs between $2,250 and $5,100, which is commonly referred to as the Part D "doughnut hole." After the beneficiary has incurred $3,600 in out-of-pocket drug expenses, the MMA provides catastrophic stop loss coverage that will cover approximately 95% of

the beneficiaries' remaining out-of-pocket drug costs for that year. MA-PDs are not required to mirror these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to the standard drug coverage delineated in the MMA. The deductible, co-pay and coverage amounts will be adjusted by CMS on an annual basis. Each Medicare Advantage plan will be required to offer a Part D drug prescription plan as part of its benefits. We currently offer prescription drug benefits through our Medicare Advantage plans and also offer a stand-alone PDP.

Dual-Eligible Beneficiaries. A "dual-eligible" beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Reform, because of economic status. Health plans that serve dual-eligible beneficiaries receive a higher premium from CMS and the government of Puerto Rico for dual-eligible members. Currently, CMS pays an additional premium, generally ranging from 30% to 45% more per member per month, for a dually-eligible beneficiary. This additional premium is based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. All qualified Reform participants could begin moving to the government-sponsored plan beginning in January 2006, and as of December 31, 2006 approximately 61,000 such participants did so. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dually-eligible members. The MMA provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, as of January 1, 2006 dual-eligible individuals receive their drug coverage from the Medicare program rather than the Reform program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

2006 Bidding Process. Although Medicare Advantage plans will continue to be paid on a capitated (PMPM) basis, as of January 1, 2006 CMS uses a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS's estimated per beneficiary fee-for-service expenses, was relabeled as the "benchmark" amount, and local Medicare Advantage plans will annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans will be required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS will have the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan's bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive.

Sales and Marketing. The marketing and sales activities of our insurance and managed care subsidiaries are closely regulated by CMS and ASES. For example, our sales and marketing materials must be approved in advance by the applicable regulatory authorities, and they often impose other regulatory restrictions on our marketing activities.

Annual Enrollment and Lock-in. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. As of January 1, 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP, or traditional fee-for-service Medicare. The initial enrollment period for 2006 began November 15, 2005 and ended on May 15, 2006 for a MA-PD or stand-alone PDP. In addition, beneficiaries had an open election period from January 1, 2006 through June 30, 2006 in which they could make or change an equivalent election. In future years, the annual enrollment period for PDPs will be from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans will occur from November 15 through March 31 of the subsequent year. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans and employer group retirees will be permitted to enroll in or change health plans during that plan year. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the

penalties described above if they later decide to enroll in a Part D plan. The new annual “lock-in” created by the MMA will change the way we and other managed care companies market

our services to and enroll Medicare beneficiaries in ways we cannot yet fully predict. The recently adopted Tax Relief and Health Care Act of 2006 allows Medicare beneficiaries to enroll throughout the year only in Medicare Advantage plans that do not offer Part D prescription drug coverage. In one of our products we do offer such coverage, thus in that particular product we can only enroll new Medicare Advantage members between November 15 and December 31 each year. We offer another product which does not offer the Part D prescription drug coverage and that is open for enrollment during the entire year. New eligibles can enroll at any time during the year at the date of eligibility. In addition, we can enroll MA members from other carriers through March 31st of the next calendar year. Dual-eligibles are allowed to enroll throughout the year.

Fiscal Intermediary. As set forth in the MMA, the Federal government, through the Centers for Medicare and Medicaid Services (CMS), will replace the current Title 18 fiscal intermediary (Fl) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation under the new Medicare Administrative Contractor (MAC) contracting authority. CMS has six years, between 2006 and 2011, to complete the transition of Medicare fee-for-service claims processing activities from the FI's and carriers to the MAC's. We are currently engaged in the analysis and evaluation of this transition process and the effect that it may have on our existing organizational structure as a Medicare carrier.

Fraud and Abuse Laws. The federal anti-kickback provisions of the Social Security Act and its regulations prohibit the payment, solicitation, offering or receipt of any form of remuneration (including kickbacks, bribes, and rebates) in exchange for the referral of federal healthcare program patients or any item or service that is reimbursed by any federal health care program. In addition, the federal regulations include certain safe harbors that describe relationships that have been determined by CMS not to violate the federal anti-kickback laws. Relationships that do not fall within one of the enumerated safe harbors are not a per se violation of the law, but will be subject to enhanced scrutiny by regulatory authorities. Failure to comply with the anti-kickback provisions may result in civil damages and penalties, criminal sanctions, administrative remedies, such as exclusion from the applicable federal health care program.

Federal False Claims Act. Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $11,000 per claim. The federal government has taken the position that claims presented in relationships that violate the anti-kickback statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen "whistleblowers" to bring actions on behalf of the federal government for violations of the Act and to share in the settlement or judgment that may result from the lawsuit.

HIPAA and Gramm-Leach-Bliley Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorizes the U.S. Department of Health and Human Services (HHS) to issue standards for administrative simplification, as well as privacy and security of medical records and other individually identifiable health information. The regulations under the HIPAA Administrative Simplification section impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. HIPAA Administrative Simplification section requirements apply to self-funded group plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ("covered entities"). Regulations adopted to implement HIPAA Administrative Simplification also require that business associates acting for or on behalf of HIPAA-covered entities be contractually obligated to meet HIPAA standards. The regulations of the Administrative Simplification section establish significant criminal penalties and civil sanctions for noncompliance.

HHS has released rules mandating the use of new standard formats with respect to certain health care transactions (e.g. health care claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and unique identifiers by employers and providers. Our managed care subsidiary was required to comply with the transactions and code set standards by October 16, 2003 and with the employer identifier rules by July 2004 and believes that it is in material

compliance with all relevant requirements. Our managed care subsidiary is required to comply with provider identifier rules by May 2007 and currently expects to meet such deadline.

HHS also sets standards relating to the privacy of individually identifiable health information. In general, these regulations restrict the use and disclosure of medical records and other individually identifiable health information held by health plans and other affected entities in any form, whether communicated electronically, on paper or orally, subject only to limited exceptions. In addition, the regulations provide patients new rights to understand and control how their health information is used. HHS has also published security regulations designed to protect member health information from unauthorized use or disclosure. Our managed care subsidiary is currently in material compliance with these security regulations.

Other federal legislation includes the Gramm-Leach-Bliley Act, which applies to financial institutions domiciled in Puerto Rico. The Gramm-Leach-Bliley Act generally placed restrictions on the disclosure of non-public information to non-affiliated third parties, and required financial institutions including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. The Gramm-Leach-Bliley Act also gives banks and other financial institutions the ability to affiliate with insurance companies, which has led to new competitors in the insurance and health benefits fields in Puerto Rico.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA), a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor (DOL). ERISA regulates certain aspects of the relationships between us, the employers who maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Other Government Programs

We participate in the Health Reform of the government of Puerto Rico (the Reform) to provide health coverage to medically indigent citizens in Puerto Rico. See "Business — Customers — Reform Sector."

Legislative and Regulatory Initiatives

The Commissioner of Insurance is currently evaluating the adoption of Rule No. 83, titled "Norms and Procedures to Regulate Insurance and Health Maintenance Holding Company Systems and the Criteria to Evaluate the Change of Control." The most recent draft of Rule No. 83 contains certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. Rule No. 83 would generally require insurance companies and HMOs within an insurance holding company system to register with the Commissioner of Insurance if they are domiciled in the Commonwealth and to file with the Commissioner of Insurance certain reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, Rule No. 83 would require prior notice, reporting and regulatory approval of certain material transactions and intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other restrictions, Rule No. 83 would restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, Rule No. 83 would restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. According to Rule No. 83, no person may make an offer to acquire or to sell the issued and outstanding voting stock of an insurance company, which constitutes 10% or more of the issued and outstanding stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, without (i) filing the appropriate documentation with the Commissioner of Insurance and (ii) obtaining the prior approval of the Commissioner of Insurance. This requirement is similar to that contained in the Insurance Code and referred to under “Regulation - Puerto Rico Insurance Laws.”

Also, on March 1, 2007, MedPac issued its semi-annual report to Congress on the Medicare payment policy. Among other things, MedPac reported that the federal government’s spending on care for beneficiaries in a private Medicare Advantage plan is on average 12% higher than spending on care for beneficiaries through the traditional Medicare program. MedPac recommends a gradual reduction in Medicare Advantage rates to ensure that payment rates between Medicare Advantage plans and the traditional Medicare program are equalized. A U.S. House of Representatives subcommittee is holding hearings on this issue, but to date no specific bill has been introduced in Congress to enact legislation to implement the MedPac recommendation.

MANAGEMENT

Directors and Executive Officers

Our directors and executive officers, and their respective ages as of March 29, 2007, are as follows:

Name	Age	Position
Wilmer Rodríguez-Silva, MD	53	Chairman of the Board
Ramón M. Ruiz-Comas, CPA	50	President, Chief Executive Officer and Director
Mario S Belaval*D	68	Vice Chairman of the Board
Jose Arturo Álvarez-Gallardo*	64	Director
Valeriano Alicea-Cruz, MD	61	Director
Luis A. Clavell-Rodríguez, MD	56	Director
Arturo R. Córdova-López, MD	63	Director
Carmen Ana Culpeper-Ramírez*	61	Director
Porfirio E. Díaz-Torres, MD	65	Director
Manuel Figueroa-Collazo, PE, Ph.D.*	55	Director
Jose Hawayek-Alemañy, MD	58	Director
Vicente J. León-Irizarry, CPA*	68	Director
Wilfredo López-Hernandez, MD	63	Director
Miguel A. Nazario-Franco*	59	Director
Juan E. Rodríguez-Díaz, Esq. *	65	Director
Jesús R. Sánchez-Colón, DMD	51	Director
Adamina Soto-Martínez, CPA*	59	Director
Manuel Suárez-Méndez, PE*D	61	Director
Fernando J. Ysern-Borrás, MDD	51	Director
Juan J. Román-Jiménez; CPA	42	Vice President of Finance and Chief Financial Officer
Socorro Rivas-Rodríguez, CPA	59	President, managed care business
Arturo Carrión, CPA	49	President, life insurance business
Eva G. Salgado	50	President, property and casualty insurance business
Luis A. Marini-Mir, DMD	58	President, Reform business
Roberto O. Morales-Tirado, Esq.	63	President, property and casualty insurance business insurance agency
Carlos D. Torres-Díaz	48	President, information technology

* Indicates directors who are independent for purposes of The New York Stock Exchange requirements.

D Mr. Belaval, Mr. Suárez Méndez and Dr. Ysern-Borrás' third and final term as members of the board of directors expire on April 29, 2007, the date of the 2007 annual meeting of shareholders.

Wilmer Rodríguez-Silva, MD. Dr. Rodríguez-Silva currently serves as chairman of our board of directors. Since 1999, he has served on our board of directors. Dr. Rodríguez-Silva is the former chief of the Gastrointestinal Section of the San Pablo Medical Center. He is also a member of the American College of Physicians, the American Gastroenterology Association, the American Society for Gastrointestinal Endoscopy, the Puerto Rico Medical Association, is a former president of the Puerto Rico Society of Gastroenterology, and the American College of Gastroenterology. Dr. Rodríguez-Silva holds a BS degree from the University of Puerto Rico and an MD degree from the University of Puerto Rico, School of Medicine.

Ramón M. Ruiz-Comas, CPA. Since May 2002, Mr. Ruiz has served as our president and chief executive officer. Mr. Ruiz has also served on our board of directors since May 2002. Mr. Ruiz-Comas served as our executive vice president from November 2001 to April 2002 and as our senior vice president and chief financial officer from

February 1999 to October 2001. From 1995 to 1999, Mr. Ruiz-Comas served as our managed care subsidiary's senior vice president of finance and from 1990 to 1995 he was vice president of finance. He is a Certified Public Accountant (CPA) and a member of the Puerto Rico Society of Certified Public Accountants, as well as the American Institute of Certified Public Accountants. He holds a *Juris Doctor* (JD) degree and a B.B.A. degree with a major in Accounting from the University of Puerto Rico.

Mario S Belaval. Since 1998, Mr. Belaval has served on our board of directors. Currently, he serves as vice-chairman of our board of directors. Mr. Belaval served as a consultant of Miradero Capital Partners from 2001 to 2005 and of the Economic Development Bank of Puerto Rico from February 1997 to February 2001. He was chairman of the board of directors of Bacardí Corporation from December 1996 to December 2001. Mr. Belaval has served as a director of the Puerto Rico Investors Tax-Free Family of Funds since March, 1995, of the Tax-Free Puerto Rico Family of Funds since February, 2001, and of UBS IRA Select Growth and Income Puerto Rico Fund since April, 1998. Mr. Belaval holds a BS degree in Economics from Franklin and Marshall College in Pennsylvania.

Valeriano Alicea-Cruz, MD. Since 2000, Dr. Alicea-Cruz has served on our board of directors. He has been an Ophthalmologist with a private practice since 1976, and has offices in two municipalities of Puerto Rico. He is an active member of the Puerto Rico Medical Association, the American Academy of Ophthalmology, the Puerto Rican Society of Ophthalmology, the University of Puerto Rico School of Medicine Alumni Society, and the Pan-American Society of Ophthalmology. He has served on the Medical Board of the Department of Transportation and Public Works, and the board of directors of Ojos, Inc. Dr. Alicea-Cruz holds a BS degree from the University of Puerto Rico, an MD degree from the University of Puerto Rico, School of Medicine, and a Postgraduate Degree in Ophthalmology from the Puerto Rico Medical Center and Affiliate Hospitals.

José Arturo Álvarez-Gallardo. Since 2000, Mr. Álvarez-Gallardo has served on our board of directors. Since 1964, Mr. Álvarez-Gallardo has served in various positions with *Méndez & Co., Inc.*, where he has served as president since 1998. He has served on the boards of directors of *Méndez & Co., Inc.*, Bamco Products Corporation, International Shipping Agency, Menaco Corporation, and Méndez Realty Equities, Inc. Mr. Álvarez-Gallardo holds a BBA degree in Business Administration from Iona College.

Arturo Carrión, CPA. Mr. Carrión has served as president of our life insurance subsidiary, GA Life, since 1998. Prior to this appointment, Mr. Carrión served as vice president of finance of GA Life from 1987 to 1998. Prior to joining GA Life, Mr. Carrión worked at KPMG LLP from 1978 to 1987. He is a Certified Public Accountant and a member of the Puerto Rico Society of Certified Public Accountants. Mr. Carrión graduated from the University of Puerto Rico with a B.B.A. degree with a major in Accounting.

Luis A. Clavell-Rodríguez, MD. Dr. Clavell-Rodríguez has served on our board of directors since 2006. He currently serves as the Medical Director at the San Jorge Children's Hospital and as the Principal Investigator for the Children's Oncology Group and the Dana Farber Acute Lymphoblastic Leukemia Consortium. He has held positions as professor of Pediatrics and Pathology at the University of Puerto Rico, School of Medicine and is a former director of Pediatric Oncology and the training program in Pediatric Hematology/ Oncology. He is certified by the National Board of Medical Examiners, the American Board of Pediatrics, and the Sub-Board of Pediatric Hematology/Oncology. He is also a member of the American Society of Hematology, American Society of Clinical Oncology and the American Society of Pediatric Hematology/Oncology. Dr. Clavell-Rodríguez received a BS degree from the Catholic University of Puerto Rico and an MD degree from the University of Puerto Rico School of Medicine. He also completed training in Pediatrics at the University of California School of Medicine and fellowships training from Harvard Medical School, Children's Hospital Medical Center in Boston, MA, and the Sidney Farber Cancer Institute.

Arturo R. Córdova-López, MD. Since 1999, Dr. Córdova-López has served on our board of directors. In addition, Dr. Córdova-López is an ad-Honorem Associate Professor of Medicine at the University of Puerto Rico, School of Medicine, since 1986. Dr. Córdova-López has served as a Staff Pneumologist and Critical Care Consultant at Pavía Hospital since 1990. He is a member of the American Thoracic Society, the American College of Physicians, the American Lung Association, the College of Physicians and Surgeons of Puerto Rico, the American Society of Bariatric Physicians, NAASO the Obesity Society, the "Socíedad Puertorriqueña de Neumología", and the American College of Chest Physicians (ACCP), where he was the previous Governor for Puerto Rico. He is Board Certified in Internal Medicine, Pulmonary Diseases, Critical Care, Managed Care Medicine, and Bariatric Medicine. He is the Medical Director and Secretary of the Board of Directors of Clínica Las Américas Guaynabo. He is active in the

private practice of ulmonology and Bariatric Medicine. He holds a BS degree in Electrical Engineering from the University of Puerto Rico, an MD degree from the same institution, and a MS degree in Epidemiology from the Harvard University School of Public Health. He is Board Certified in Internal Medicine, Pulmonary Diseases, Critical Care, Managed Care Medicine, and Bariatric Medicine.

Carmen Ana Culpeper-Ramírez. Ms. Culpeper-Ramírez has served on our board of directors since 2004. She served as the director of the Small Business Administration (SBA) for the Puerto Rico and U.S. Virgin Islands District from April 2004 until April 2007. From 2000 to March 2004, she was president and chief executive officer of C. Culpeper & Associates, a management consulting business, which offered organizational development, project and financial management services. She serves as a member of the board of directors of Levitt Homes, Inc. Ms.

Culpeper-Ramírez has served as chairwoman of the board of the San Juan Human Capital Development Board, and as a member of the board of directors of Santander BanCorp, Centennial Communications Corporation and of Intech de Puerto Rico. From 1997 to 1999, Ms. Culpeper-Ramírez worked for two years as President of the Puerto Rico Telephone Company, the tenth largest telephone company in the United States, and was responsible for its sale to GTE/Verizon. From 1999 to 2000, she also served as president of the Puerto Rico Chamber of Commerce. She holds a BBA in Finance from the University of Puerto Rico and an MBA from the University of Pennsylvania, Wharton School of Business (International Business).

Porfirio E. Díaz-Torres, MD. Since 2000, he has served on the board of directors of the Corporation. He is Assistant Secretary of the board of directors of Triple-S, Inc. and member of the board of directors of Seguros Triple-S, Inc. He is also the Secretary of the board of directors of Interactive Systems, Inc. and the Vice Chairman of Signature Insurance Agency, Inc. Since 1988, Doctor Díaz-Torres serves as the Director of the Cardiology, Division of the Cardiology and Nuclear Center in San Juan, Puerto Rico. Doctor Díaz-Torres is also President of Old Harbor Brewery of Puerto Rico, Inc. and Di' Rome Productions, Inc. He is an active member of the American College of Cardiologists and American Medical Association. He is active on the medical staff of *Centro Cardiovascular de Puerto Rico y del Caribe* and Auxilio Mutuo Hospital. Doctor Díaz-Torres holds a BBA degree in Business Administration from the University of Puerto Rico and an MD degree from *Universidad Central del Este* in the Dominican Republic.

Manuel Figueroa-Collazo, PE, PhD. Since 2004, Dr. Figueroa-Collazo has served on our board of directors. Since 1999, Mr. Figueroa-Collazo is President of VERNET, Inc., an educational software development Company located in Caguas, Puerto Rico. Mr. Figueroa-Collazo is also member of the Board of Directors of INTECO, Puerto Rico Products Association, EPSCOR, and *Vivero de Tecnología y Ciencia de Puerto Rico*. He has 12 years of experience in senior management positions and over twenty years of exposure at all management levels within the communications and systems industries. He was general manager for Lucent Technologies, Mexico and a Department Head at AT&T Bell Laboratories. Dr. Figueroa-Collazo holds a BS, MS, and PhD in Electrical Engineering from the Florida Institute of Technology, and he attended Advanced Management Programs in INSEAD Fontainebleau, France, and University of Pennsylvania, Wharton School of Business.

*José Hawayek-Alemañy, MD***.** Since 2005, Dr. Hawayek-Alemañy has served on our board of directors. Since 1976, he has been a professor at the University of Puerto Rico, School of Medicine. From 1988 to 1998, he was director of the Office of Graduate Medical Education at the University of Puerto Rico, School of Medicine and, from 1998 to 2002, he was Dean of Academic Affairs at the University of Puerto Rico, School of Medicine. He is president of the OB-GYN Section of the Puerto Rico Medical Association. Since 2000, he has represented Puerto Rico in the Maternal Mortality & Morbidity Committee of the American College of OB-GYN. From 2003 to 2005, he was Senate Member and Treasurer of the OB-GYN Section of the Medical College of Puerto Rico. He also served as president of the Medicare Carrier Advisory Committee in Puerto Rico. He holds a BS degree in pre-medicine from the University of Puerto Rico, Mayagüez Campus, an MD degree from the University of Puerto Rico, School of Medicine, and a specialty in OB-GYN from University Hospital.

Vicente J. León-Irizarry, CPA. Since 2000, Mr. León-Irizarry has served on our board of directors. He is a Certified Public Accountant (CPA) and since January 2002, he has been a business consultant. He worked as consultant for Falcón-Sánchez & Associates, a certified public accounting firm, from February 2000 to December 2001, and as a business consultant from January 1999 to February 2000. He is a member of the Puerto Rico Society of Certified Public Accountants. He holds a B.B.A. degree with a major in Accounting from the University of Puerto Rico.

Wilfredo López-Hernández, MD. Since 1999, Dr. López-Hernández he has served on our board of directors. Dr. López-Hernández has had a private medical practice since 1979. He was an associate professor at the University of Puerto Rico, School of Medicine, an associate professor at the San Juan Bautista School of Medicine, and chief of service at San Rafael Hospital. Dr. López is a partner in Quadrangle Development, SE. Since 1979, he has been a member of the Puerto Rico Urological Association, *Société International D'Urologie*, American Confederation of

Urology, and the American Urological Association. He holds a BS degree from the University of Puerto Rico, an MD degree from the University of Santiago de Compostela, Spain, and a specialty in Urology from the University of Puerto Rico, School of Medicine.

Luis A. Marini-Mir, MD. Dr. Marini has been president of our Reform business since October 1999. Prior to his appointment, Dr. Marini served as dental director of our managed care business. from February 1998 to October 1999. From April 1975 to December 2000, Dr. Marini had a pediatric dentistry private practice. Dr. Marini is a former dean of the University of Puerto Rico School of Dentistry. Dr. Marini received a degree from the University of Puerto Rico (Mayagüez Campus) with a concentration in pre-medicine and obtained a degree of Doctor in Medical Dentistry (D.M.D.) from the University of Puerto Rico School of Dentistry. He also obtained a Certificate in Pediatric Dentistry from the University of Puerto Rico, School of Dentistry.

Roberto O. Morales-Tirado, Esq. Mr. Morales was appointed president of our property and casualty insurance business insurance agency in February 2006. Prior to being appointed to this position, Mr. Morales served as president and chief executive officer of our life insurance business from 2000 through February 2006. From 1998 to 2000, Mr. Morales served as a consultant for us. From 1993 to 1998, Mr. Morales served as president and chief executive officer of AIG Life Insurance Company of Puerto Rico. Mr. Morales received a B.A. degree from the University of Puerto Rico and a *Juris Doctor* degree from the Interamerican University of Puerto Rico School of Law.

Miguel A. Nazario-Franco. Since 2004, he has served on our Board of Directors of the Corporation and the board of Triple-S, Inc. Mr. Nazario is Assistant Secretary of our Board of Directors of the Corporation and Assistant Treasurer of the Board of Directors of Triple-C, Inc. Mr. Nazario-Franco is an active member of the Board of Directors of Ferré Investment Fund, and *Empresas Santana*. From 1994 to 2002, Mr. Nazario-Franco worked for Puerto Rican Cement Co., Inc. where he held various positions, including those of President, Chief Executive Officer, and President of the Board of Directors. From 1995 to 2005 he served as a member of the Board of Directors of El Día, Inc. From 2002 to 2004, he served as a member of the Advisory Board of the Puerto Rico Department of Education and *Consejo Asesor de la Industria de la Construcción.* He also served on the Board of Directors of the Puerto Rico Aqueduct and Sewer Authority and *Compañía para el Desarrollo Integral de la Peninsula de Cantera* until December 2005 and in the Board of Directors of Puerto Rico Electric Power Authority until January of 2006. Mr. Nazario-Franco holds a BBA in Accounting from the University of Puerto Rico.

Socorro Rivas-Rodríguez, CPA. Ms. Rivas-Rodríguez has served as president and chief executive officer of our managed care business since May 2002. Prior to her appointment as president and chief executive officer, Ms. Rivas-Rodríguez served in various positions at our managed care business, including general manager from 1999 to 2002, and executive vice president from 1990 to 2002, and director of internal audit from 1982 to 1990. She has been a Certified Public Accountant since 1987 and a member of the Puerto Rico Society of Certified Public Accountants. Ms. Rivas-Rodríguez has a B.A. degree with concentrations in mathematics and accounting from the University of Puerto Rico.

Juan E. Rodríguez-Díaz, Esq. Since December 2004, Mr. Rodríguez-Díaz has served on our board of directors. Mr. Rodríguez-Díaz is a commercial, corporate and tax attorney authorized to practice law in Puerto Rico and New York who currently works as senior and managing partner of Totti & Rodríguez Díaz. He has worked in various prestigious law firms including Baker & McKenzie, McConnell Valdés, and Sweeting, Pons, González & Rodríguez. Mr. Rodríguez-Díaz also served as Undersecretary of the Department of Treasury of Puerto Rico from 1971-1973. He serves as a member of the boards of directors of *Industrias Vassallo, Inc.*, Vassallo Research and Development, Inc., Syroco, Inc., Ochoa Industrial Sales Corp., Ensco Caribe, Inc., Triangle Cargo Services, Inc., and Luis Ayala Colón Sucrs., Inc. Mr. Rodríguez-Díaz holds a BA degree from Yale University, a *Juris Doctor* (JD) from Harvard University and a Masters of Laws (LLM in taxation) from New York University School of Law.

Juan J. Román-Jiménez, CPA. Mr. Román-Jiménez has served as our vice president of finance and chief financial officer since 2002. Prior to his appointment as chief financial officer, Mr. Román-Jiménez served as executive vice-president of our Reform business from 1999 to 2002 and vice-president of finance of Triple-C, Inc. from 1996 to 1999. Prior to joining us, Mr. Román-Jiménez worked at KPMG LLP from 1987 to 1995. He has been a Certified Public Accountant and a member of the Puerto Rico Society of Certified Public Accountants as well as the American

Institute of Certified Public Accountants since 1989. He earned a B.A. in Business Administration with a concentration in Accounting from the University of Puerto Rico, Rio Piedras.

Eva G. Salgado. Ms. Salgado has served as president of our property and casualty insurance business since July 2003. Prior to this appointment, Ms. Salgado served in various positions in our property and casualty insurance

business, including, senior vice president of the underwriting department from 2002 to 2003, vice-president of the underwriting department from 1997 to 2002 and vice-president of marketing. Prior to joining our property and casualty insurance business, Ms. Salgado worked at Integrand Assurance Company as senior vice-president of the underwriting department from 1992 to 1996. Ms. Salgado has a B.A. from the University of Puerto Rico with a concentration in Finance. She also studied underwriting at the Insurance Institute of America.

Jesús R. Sánchez-Colón, DMD. Since 2000, Dr. Sánchez-Colón has served on our board of directors. He has been secretary of our board of directors since 2002. Dr. Sánchez-Colón is a dentist and has had a private practice since 1982. He is member of the College of Dental Surgeons of Puerto Rico, where he served as secretary and auditor, and he is also a member of the American Dental Association. He currently serves as chairman of the board of directors of *B. Fernández & Hermanos. Inc.* He has been chairman of the board of directors of Delta Dental Plan of Puerto Rico and vice chairman of the board of directors of the Corporation for the Economic Development of the City of San Juan. Dr. Sánchez-Colón holds a BA in Psychology from St. Louis University, a DMD from the University of Puerto Rico, and a Postgraduate General Practice Residency at the Veterans Administration Hospital in San Juan, Puerto Rico.

Adamina Soto-Martínez, CPA. Since 2002, Ms. Soto-Martínez has served on our board of directors. She is assistant treasurer of our board of directors. She is a Certified Public Accountant (CPA) and a partner and a founding member of the firm Kevane Soto Pasarell Grant Thornton, LLP, certified public accountants, where she has worked since 1975. Ms. Soto-Martínez is a member of the Puerto Rico Society of Certified Public Accountants and the American Institute of Certified Public Accountants. She is a graduate of the University of Puerto Rico.

Manuel Suárez-Méndez, PE. Since 1999, Mr. Suárez-Méndez has served on our board of directors. Since 1972, Mr. Suárez-Méndez has owned R.B. Construction Corporation. He has been member of the Puerto Rico College of Engineers, the Home Builders Association, the National Society of Professional Engineers, the General Contractors Association of America, where he served as chairman in 1994 and as a director for 12 years, and the American Concrete Institute. Mr. Suárez-Méndez holds a BS degree in Civil Engineering from the University of Puerto Rico, Mayagüez Campus, and has completed postgraduate study in Urban Planning at the University of Puerto Rico.

Carlos D. Torres-Díaz. Mr. Torres-Díaz has served as president of our information technology subsidiary since 1996. Prior to his appointment, Mr. Torres-Díaz served as vice-president of systems development from April 1990 to January 1996. Before joining us, Mr. Torres-Díaz served as EDP Administration Manager at Banco Popular de Puerto Rico. Mr. Torres has a B.B.A. degree from the Interamerican University of Puerto Rico with a concentration in the Management of Information Systems.

Fernando J. Ysern-Borrás, MD. Since 1999, Dr. Ysern-Borrás has served on our board of directors. He served as chairman of our board of directors from 2002 to 2005. Since 1986, he has worked with *Grupo Pediátrico* in Caguas, Puerto Rico. He has worked in several hospitals and has been Director of the Pediatric Department at the Inter-American Hospital of Advanced Medicine. He has held positions as Assistant Professor at the University of Puerto Rico, School of Medicine, the San Juan Bautista School of Medicine, and Adolescent Medicine Fellowship Director at the Caguas Regional Hospital. He was president of the Health and Social Welfare Commission while he served as a member of the Municipal Assembly of Caguas. He is a member of the Puerto Rico Medical Association and the American Academy of Pediatrics. Dr. Ysern-Borrás holds an MD degree from the University of Puerto Rico, School of Medicine. He has a specialty degree in Pediatrics from the University Pediatrics Hospital in Río Piedras, Puerto Rico, and a subspecialty in Adolescent Medicine. He is also Board Certified in Pediatrics.

Composition of the Board of Directors

Our articles and bylaws provide that the board of directors shall consist of 19 members, 10 of whom must be representatives of the community (as such term is defined by the BCBSA).

Our board of directors is divided into three groups as nearly equal in number as possible, with each group having at least five members and with the term of office of one class expiring each year. Each director serves for a term ending on the date of the third annual meeting of shareholders following the annual meeting at which such director was elected or until his successor has been elected and qualified. In the event that there is a vacancy on the board of directors, the person elected by the board to fill the vacancy will serve the rest of the term of the person who created the vacancy and may be reelected for two additional successive terms. In accordance with our bylaws,

the president and chief executive officer, who is also a member of the board of directors, is excluded from the three groups of directors. In addition, our articles and bylaws provide that, with the exception of the president and chief executive officer, directors may not be elected to the board for more than three terms or serve as such for more than nine years of service. The last election of directors was held on April 30, 2006.

The terms of our Group 3 directors, Mr. Belaval, Ms. Culpeper, Mr. Figueroa, Mr. Nazario, Mr. Rodriguez-Diaz, Mr. Suarez and Dr. Ysern expire at our 2007 shareholders' meeting. The terms of our Group 1 directors, Dr. Rodriguez-Silva, Dr. Cordova, Dr. Hawayek, Dr. Lopez and Ms. Soto expire at our 2008 shareholders' meeting. The terms of our Group 2 directors, Dr. Alicea, Mr. Alvarez, Dr. Clavell, Dr. Diaz, Mr. Leon and Dr. Sanchez, expire at our 2009 shareholders' meeting.

Meetings of the Board of Directors

Scheduled meetings of the board are held at least quarterly. Special board meetings are held when convened by the Chairman, or by at least five directors. The board of directors met nineteen times during 2006. All directors, with the exception of Mr. Manuel Suárez-Méndez, attended at least 75% of the scheduled board of directors' meetings and meetings held by Committees of which they were members. Due to family health related issues, this percentage was not met by Mr. Suárez-Méndez.

While we encourage directors to attend our annual meeting of shareholders, we have not adopted a formal policy that all directors must attend annual meetings of shareholders. All of our directors attended the last annual meeting of shareholders.

Director Independence

The board has determined that Mr. Álvarez-Gallardo, Mr. Belaval, Ms. Culpeper-Ramírez, Mr. Figueroa-Collazo, Mr. León-Irizarry, Mr. Nazario-Franco, Ms. Soto-Martínez, Mr. Rodríguez-Díaz and Mr. Suárez-Méndez have no material relationship with us and are independent within the meaning of NYSE rules. The board has adopted the NYSE director independence standards as guidelines for corporate governance policy.

Board of Directors Committees

Our bylaws provide that the board of directors shall have the following standing committees: corporate governance committee, finance committee, resolutions and regulations committee, nominations committee, compensation committee and audit committee. All members of the standing committees serve for a one year term. The board may create any other committee it deems necessary for the proper operation of our business. In addition to these standing committees, we have a number of ad hoc committees.

Nominations Committee

The duties of the nominations committee are to (i) identify and recommend individuals who are best qualified to become members of the board, who will be presented as candidates endorsed by the board at the annual shareholders' meetings, (ii) recommend to the board the best qualified candidates to fill vacancies on the board, (iii) evaluate the performance of the directors pursuant to criteria and objectives established by the board from time to time; (iv) establish and periodically review the qualifications of the candidates to be endorsed by the board and (v) recommend to the board the best qualified candidates to occupy the position of our president.

The members of the committee are Dr. Ysern-Borrás (Chair), Mr. Álvarez-Gallardo, Dr. Clavell-Rodríguez, Dr. Córdova-López, Dr. Díaz-Torres, Dr. Hawayek-Alemañy, Dr. Rodríguez-Silva, Dr. Sánchez-Colón and Mr. Suárez-Méndez. The board has determined that Messrs. Álvarez-Gallardo and Suárez-Méndez are independent within

the meaning of NYSE rules.

Compensation Committee

The duties of the compensation committee are to (i) develop, recommend and review the compensation policies for our executive officers, (ii) recommend to the board the compensation of our executive officers and (iii) recommend to the board those changes to the compensation levels of our directors that it deems necessary.

The members of the committee are Ms. Soto-Martínez (Chair), Mr. Belaval, Ms. Culpeper-Ramírez, Mr. León-Irizarry, and Dr. Rodríguez-Silva. The board has determined that all members of the compensation committee, with the exception of Dr. Rodríguez-Silva, are independent within the meaning of NYSE rules.

Audit Committee

The audit committee reviews the following matters: (i) whether we have adequate internal controls to safeguard our assets, generate reliable financial information and assure our compliance with applicable laws and regulations, (ii) activities of our Internal Audit Office, (iii) results from audits made by regulators, (iv) our consolidated financial statements and (v) the annual report prepared by external auditors. In addition, the audit committee appoints the independent public accounting firm to serve as our external auditors and the vice president of internal audit, when such position becomes vacant.

The members of the committee are Mr. Belaval (Chair), Ms. Culpeper-Ramírez, Mr. Figueroa-Collazo, Mr. León-Irizarry, Mr. Nazario-Franco, Ms. Soto-Martínez and Mr. Suárez-Méndez. The board has determined that all members of the audit committee are independent within the meaning of NYSE rules.

The board of directors has determined that Mr. León-Irizarry is the audit committee financial expert.

Code of Business Conduct and Ethics

Our board of directors has established a code of business conduct and ethics that applies to our employee, officers and directors. Any waiver of the code of business conduct and ethics may be made only by our board of directors and will be promptly disclosed as required by law or stock exchange regulations. The board of directors has not granted any waivers to the code of business conduct and ethics.

Corporate Governance Guidelines

Our board of directors has adopted corporate governance guidelines that comply with the requirements of the NYSE and the regulations of the SEC.

Compensation Committee Interlocks and Insider Participation

None of the members of the compensation committee is or has been one of our officers or employees. None of our executive officers served on any board of directors' compensation committee of any other company for which any of our directors served as an executive officer at any time during 2005. Other than disclosed in "Certain Relationships and Related Party Transactions" in this prospectus, none of the members of the compensation committee had any relationship with us requiring disclosure under Item 404 of the SEC Regulation S-K.

Directors' Compensation and Benefits

The following table summarizes the fees or other compensation that our directors earned for services as members of the board of directors or any committee of the board of directors during 2006.

Name	Fees Earned or Paid in Cash [1]	All Other Compensation [2]	Total
Wilmer Rodríguez Silva, MD	$ 42,200	$ 16,035	$ 58,235
Jesús R. Sánchez Colón, DMD	27,550	16,035	43,585
José Hawayek Alemañy, MD	24,800	16,035	40,835

Vicente J. León Irizarry, CPA	31,550	11,194	42,744
Arturo Córdova López, MD	23,650	16,035	39,685
Fernando J. Ysern Borrás, MD	23,110	16,035	39,145
Mario S Belaval	28,000	11,194	37,194
José Arturo Álvarez Gallardo	27,900	11,194	39,094
Porfirio E. Díaz Torres, MD	26,400	11,194	37,594
Miguel Nazario Franco	27,850	11,194	39,044
Manuel Figueroa Collazo, PE	23,750	11,194	34,944

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Name	Fees Earned or Paid in Cash [1]	All Other Compensation [2]	Total
Wilfredo López Hernández, MD	23,700	11,194	34,894
Juan E. Rodríguez Díaz, Esq.	23,100	11,194	34,294
Manuel Suárez Méndez, PE	23,050	11,194	34,244
Adamina Soto Martínez, CPA	28,250	5,597	33,847
Carmen Ana Culpeper Ramírez	25,800	5,597	31,397
Valeriano Alicea Cruz, MD	24,050	6,133	30,183
Luis A. Clavell Rodríguez, MD [3]	19,200	7,463	26,663
Fernando L. Longo Rodríguez, MD [4]	8,500	3,731	12,231

(1) Directors who are also employees do not receive any compensation for service as members of the board of directors or any committee of the board of directors, or the board of directors of a subsidiary. Directors who are not employees are paid an annual fee of $8,000 as directors of Triple-S Management Corporation and $7,000 as directors of Triple-S, Inc. The Chairmen of the Board of TSM and TSI receive an annual retainer of $10,500 and $9,500, respectively.

The following is the amount received by each Director for board of directors or committee meetings:

Meetings	Chairman	Director
Board of Directors of TSM and TSI	$ 200	$ 200
Audit Committee	350	250
Other Committees of TSM	300	200
Other Subsidiaries' Boards and Committees	250	150

(2) Represents the cost of a healthcare plan provided for the director and his/her spouse and children while at the board of directors.

At present, members of the board of directors that have served six or more years in the board of directors are eligible for continued coverage in the TSM board of directors' Medical Plan until their death. Spouses and dependents may receive coverage under this plan only if premiums for the coverage are paid by the member. In the event of the member's death, the eligible surviving spouse is eligible to continue receiving healthcare coverage for the rest of his or her life for a premium. Healthcare coverage is provided based on the following:

Age	Health Insurance Coverage Options
Under 55	No coverage
55 to 65	Regular coverage
65 and up	Medicare supplement, including dental and pharmacy

TSM pays one hundred percent of the cost for the eligible member. The aggregated present value of this benefit for 2006 was approximately $280,000. The board of directors has authorized the elimination of this benefit, effective May 1, 2007, for current and future members.

In addition, the board of directors holds an annual off-site meeting to discuss our strategic direction and to comply with educational requirements, among other purposes. Members are allowed to be accompanied by their spouses, whose transportation and other costs are paid by us. Certain executives and their spouses accompany the board of directors as it may be necessary. Some of the activities at this meeting could be considered non-work related; however, due to the difficulty in allocating the specific cost to each member and since total

cost is estimated at less than $5,000 per person, such amount was not included in the above table under “All Other Compensation.”

(3) Term as member of the board of directors began on May 1, 2006.

(4) Term as member of the board of directors expired on April 30, 2006.

Compensation Discussion and Analysis

The Compensation Committee (for purposes of this analysis, the Committee) of the board of directors oversees the design and administration of the Company’s executive and director compensation programs. The Committee works to ensure that the total compensation paid to the executive officers and outside directors is fair, reasonable and competitive.

The individuals who served as our chief executive officer and chief financial officer during fiscal 2006, as well as the other individuals included in the Summary Compensation Table, are referred to as the “Named Executive Officers.”

The Committee currently comprises a majority of independent directors (four out of five), and is responsible for the administration of the Company's executive compensation program. As required by its new charter, the Committee will comprise only independent directors by May 2007. The Committee met seven times during 2006.

The Committee has the sole authority to engage the services of outside consultants to assist them. The Committee retained Frederic W. Cook & Co., Inc. (Cook) as its compensation consultant during 2006 to advise the Compensation Committee in all matters related to the executives' and directors' compensation.

Our executive compensation program is designed to support the attainment of our vision, business strategy, and operating imperatives. Specifically, we believe that the most effective executive compensation program is one that is designed to reward the achievement of specific annual and long-term goals which align the executives' interests with those of the shareholders, and ultimately improve shareholder value.

To this end, our compensation program is designed to accomplish the following objectives:

- Reinforce the business values through the alignment of our efforts to deliver superior results for customers and shareholders, belief in good governance, socially responsible business practices, and high ethical standards.

- Reinforce a high performance culture with clear emphasis on accountability and variable pay. The variable pay program is intended to drive a high performance culture that emphasizes both near and longer-term results.

- Deliver compensation that is reasonable and competitive so that we can attract and retain talented leaders and motivate those leaders to achieve superior results. At the same time, we believe that compensation should be set responsibly to ensure a reasonable rate of return on our human capital expenditures.

- Require levels of share ownership that increase with role scope once we become a public corporation. Executives will be required to own and hold a number of shares while in executive or policymaking roles to align their economic interests with other shareholders.

Determining Executive Compensation

We compare our compensation to that of companies with which we compete for talent, capital, and customers. Those companies include private or publicly-held companies, stand-alone businesses or divisions of larger institutions. Our size and/or organization complexity are considered when selecting comparable companies and data analysis methods. Within our general competitive framework, specific comparisons may vary by type of role.

Cook provided the Committee with relevant market data and alternatives to consider when making compensation decisions. Using data prepared by Cook, the Committee compared each element of total compensation to several competitive reference groups, including a defined list of direct industry competitors ("Insurance and Managed Care Peer Group"), other public companies operating in Puerto Rico, and a broader industry group of similarly-sized insurers and general service companies.

The Insurance and Managed Care Peer Group consists of companies against which the Committee believes we will compete for talent, capital, and customers or are comparable to us. The companies comprising the Insurance and Managed Care Peer Group are:

AMERIGROUP Corporation	Delphi Financial Group, Inc.	Molina Healthcare, Inc.
21st Century Insurance Group	Erie Indemnity Company	Sierra Health Services, Inc.

Alleghany Corporation	HCC Insurance Holdings, Inc.	State Auto Financial Corporation
AmerUs Group Co.	HealthSpring, Inc.	WellCare Health Plans, Inc.
Aspen Insurance Holdings Ltd	Infinity Property & Casualty Corporation	Zenith National Insurance Corporation
Centene Corporation	Magellan Health Services	

For comparison purposes, our annual revenues are at the median of the Insurance and Managed Care Peer Group. Total compensation is targeted at the median (50th percentile) of the Insurance and Managed Care Peer Group for all components of pay, including: base salary, short- and long-term variable pay opportunities, benefits and perquisites.

Based on our compensation philosophy, a significant percentage of total compensation is delivered in the form of incentive compensation. There is no pre-established policy or target for the allocation between either cash and non-cash or short-term and long-term incentive compensation. Rather, the Committee reviews competitive pay information provided by Cook as well as our current operating goals and environment to determine the appropriate level and mix of incentive compensation. Actual amounts earned from incentive compensation are realized only as a result of individual or Company performance, depending on the type of award, based on a comparison of actual results to pre-established goals.

Role of Individual Pay Components

Executive compensation historically has been delivered predominantly through base salary and annual cash bonuses, as we have not previously awarded long-term incentives due to our status as a private company. Going forward, we intend to deliver long-term incentives, believing that they are an important and essential element of the total compensation program that will help to ensure our ability to attract, motivate, and retain top talent as a public company.

Base Salary

Base salaries are used to recognize an employee's immediate contribution to the organization, experience, knowledge, and responsibilities of each particular role. It is also used to compensate the Named Executive Officers for assuming a significant level of responsibility, to provide financial stability, to be market competitive, and to secure an appropriate level of incentive.

Our Salary Adjustment Policy (the Policy) establishes that salary adjustments be based on a number of relevant factors, including: particular importance of the position to us, individual performance, growth in position, market level increases, our financial performance and ability to pay. Also, the Policy establishes that base pay adjustments send clear performance messages and make moderate distinctions based on performance; for executives, significant distinctions in performance are recognized through our annual cash program. In addition, this Policy requires that timing for increases be consistent with market practice, and base salaries for executives are reviewed and adjusted as necessary on an annual basis to ensure pay levels remain competitive, as well as the time of promotion or changes in responsibilities.

Annual Cash Bonus

The annual cash bonus portion of an executive's total compensation opportunity is intended to accomplish a number of objectives, including: reinforce the optimization of operating results throughout the year, achievement of our stated objectives; pay for performance and reinforce individual accountability; support our long-term objective to create shareholder value; and to provide market competitive cash compensation when performance objectives are met or exceeded. This bonus can be highly variable from year to year depending on actual performance results.

The annual cash bonus is based on achievement of the Company's and individual business units' goals that are established at the beginning of each year. Goals are approved by the board of directors and include financial goals, such as consolidated premium earned and net income growth, as well as specific performance goals for each Named Executive Officer. The annual amount, if any, of the annual cash bonus is based on an evaluation of each Named Executive Officer's performance and on the financial goal achievement. Depending on the performance for the year, payment under the annual incentive may range from 0 percent to 150 percent of the target bonuses established by the Committee. The Committee approved the awards and has discretion to determine any charges to the amount to be

paid. Final recommendation of the Committee is approved by the board of directors. Amounts paid to the Named

Executive Officer for 2006 are shown on the Summary Compensation Table — Non-Equity Incentive Plan Compensation column.

Target bonuses are currently established at 70 percent of base salary for the Chief Executive Officer (CEO) and from 50 percent to 70 percent for the other Named Executive Officers. For the CEO and the Chief Financial Officer, the financial performance goals are based 80 percent on the Company's actual financial performance, against the 2006 corporate objectives, and 20 percent on non-financial performance. This includes individual objectives that can be quantitative or qualitative. For all other executive officers, the performance measures are based 30 percent on the Company's actual financial performance, against 2006 corporate objectives, 50 percent on the actual performance of the corresponding business unit for which the executive is responsible, and 20 percent on the executive officer's performance, as established by the Committee.

We also pay an annual bonus each December to all of our active employees, including the Named Executive Officers. This bonus is determined based on a non-performance predetermined formula and paid if the employee had worked more than 700 hours as of September 30 of each year and is an employee at the date of payment. The amount paid under this bonus approximates nine percent of base salary and, with respect to the bonus payable to the Named Executive Officers, is included in the bonus column of the Summary of Compensation Table.

Retirement Programs

Executive officers participate in our qualified and non-qualified employee retirement programs designed to provide retirement income. Our qualified and nont-qualified pension plans provide a retirement income base.

Non-Qualified Deferred Compensation Plan

The purpose of this program is to provide certain executives who elect to become participants with the opportunity of deferring a portion of their compensation to a later date and benefiting from the tax advantages related thereto.

Long-Term Incentive Awards

Historically, we have not made any long-term incentive awards to executives due to our status as a private company. Going forward, we believe that long-term incentives are an important and essential element that need to be offered as part of the total compensation program of the Company as a public entity to ensure our ability to attract, motivate, and retain top talent. As such, we intend to deliver long-term incentives to key management to accomplish a number of important objectives:

- Align management and shareholder interests
- Balance the short-term orientation of other compensation elements
- Provide a variable portion of total compensation tied to long-term market and financial performance of the Company
- Build executive stock ownership
- Hold executives accountable for their long-term decisions
- Reinforce collaboration across the Company
- Retain key talent over the long term

· Share success with those who directly impact our performance results

Long-term incentives may be delivered through a variety of award types that we may adopt in the future, including: stock options, restricted stock/units, performance-based equity ("performance shares"), performance-based cash ("performance cash"), and other equity/non-equity award types (e.g., stock SARs/cash SARs). We intend to provide long-term awards through a combination of some of the above mentioned types of award.

IPO and Annual Equity Awards

In association with the planned IPO, and consistent with typical competitive practice, on the date of the closing of the initial public offering, the we intend to deliver equity awards to selected officers, including the executive officers. The form of these awards is intended to be consistent with the ongoing annual long-term incentive awards that we intend to make in the future.

IPO and annual equity awards are intended to accomplish a number of important objectives:

- Encourage a successful IPO event
- Create an immediate and significant equity stake for senior managers
- Strongly align management and shareholder interests by encouraging and rewarding market-based and financial operating performance of the Company
- Recognize the historic lack of long-term incentive awards
- Retain key management following the IPO

At the time of each award, the Committee will determine the terms of the award, including, if appropriate, the performance period (or periods) and the performance objectives relating to the award of performance shares. At the conclusion of a performance share award performance period, the Committee will review actual performance versus the pre-established performance goals to determine whether the performance objectives were met in whole or in part, and the associated payment that may be due as a result.

Role of Executive Officers in Compensation Decisions

The Committee makes all compensation decisions for Named Executive Officers of the Company. Decisions regarding the non-equity compensation of other executive officers are made by the the Chief Executive Officer. The CEO annually reviews the performance of each Named Executive Officer. The conclusions reached and recommendations based on these reviews, including with respect to salary adjustments and annual incentive award amounts, are presented to the Committee. The Committee approves the compensation of the Named Executive Officers, including the CEO, and makes recommendations for final approval to the board of directors.

Compensation of Named Executive Officers for 2006

As part of our strategic development, we announced in January 2006 that we were going to recommend to the shareholders to commence the process of becoming a public corporation. As part of that process, the Committee has been evaluating the different components of compensation of the executive officers. The purpose is to ascertain compensation at adequate levels (defined as total compensation targeted at median external pay levels) when compared with peer companies and to retain its executive officers.

As part of the engagement of Cook, the Committee is reviewing each pay component to align compensation for the first time to that of similar companies. The main purpose is to assure that we have established a competitive compensation program. Based on the initial analysis, the main component of compensation we do not provide is a long-term incentive award program. The Committee is in the process of evaluating this component of the compensation. In addition, total compensation for the Named Executive Officers is below the median pay level of comparable companies at this moment.

Base Salary

In setting base salaries for 2006, the Committee considered the following factors:

- The corporate budget, meaning our overall budget for base salary increases. The corporate budget was established based on planned performance for 2006. The objective of the budget is to allow salary increases to retain and motivate successful performers while maintaining affordability within the our business plan.

- The relative pay differences for different job levels.

- Individual performance base salary increases were driven by individual performance assessments.

- Evaluation of peer group data specified to each executive position, where applicable. However, the Compensation Committee may exercise subjective judgment in determining final increases.

In establishing Mr. Ruiz's base salary for 2006, the Committee applied the principles described above. In an executive session, the Committee assessed Mr. Ruiz's 2005 performance, based on established corporate goals and financial objectives. They considered the Company's and Mr. Ruiz's accomplishment of objectives that had been established at the beginning of the year, strategic direction of the Company and its own subjective assessment of his performance. The Committee approved the salary increase of Mr. Ruiz and recommended the increase to the board of directors, who also approved it.

The salary increase of Mr. Román was determined based on the factors mentioned above. His increase was greater than the increase for other executives. His salary increase was necessary to recognize his performance, new requirements based on the aforementioned strategic direction of the Company, and to improve the competitive positioning of his pay.

For all other Named Executive Officers salary increases were based on the aforementioned principles and in line with budget increases.

Non-Equity Incentive Plan

The non-equity incentive award for 2006 was based on the performance of the Company against the stated objectives. For 2006, our reported net income of $55 million, which exceeded the targeted level and reached the superior level. Also, total operating revenues, excluding net investment income, was $1.5 billion, which was just below targeted level.

In February 2007, the Committee and the board of directors approved payments to the Named Executive Officers under the 2006 non-equity incentive plan, in the amounts set-forth below in the Summary Compensation Table. Payments were made within the parameters established.

Summary Compensation Table

Name and Principal Position	Year	Salary[1]	Bonus[2]	Non-Equity Incentive Plan Compensation	Change in Pension Value and Non-Qualified Deferred Compensation Earnings[3]	All Other Compensation[4]	Total
Ramón M. Ruiz, President & CEO of Triple-S Management Corporation	2006	$ 492,274	$ 45,325	$ 386,020	$ 115,000	$ 72,868	$ 1,111,487
Juan José Román, Vice President of Finance & CFO of Triple-S Management Corporation	2006	285,000	26,325	165,758	35,000	21,474	533,557
Socorro Rivas, President of Triple-S, Inc.	2006	380,500	35,079	299,895	175,000	67,595	958,069
Eva Salgado, President of Seguros Triple-S, Inc.	2006	264,500	24,446	207,664	48,000	28,802	573,412
Luis A. Marini, President of Triple-C, Inc.	2006	223,700	20,706	138,856	48,000	40,782	472,044

(1) Amounts represent base salary. Some of the Named Executive Officers deferred a portion of their salary under the non-qualified deferred salary plan, which was included in the Non-qualified Deferred Compensation Table.

(2) Represents annual non-performance base bonus. Refer to the Compensation Discussion and Analysis — Annual Cash Bonus for detailed explanation.

(3) The amounts represent the actuarial increase in the present value of the Named Executive Officer's benefits under the our pension plan, and the Supplemental Benefit Plan, further described below. The increase was calculated using the interest rate, discount rate and form of payment assumptions consistent with those used in our financial statements. The calculation assumes benefit commencement is at normal retirement age (65), and was calculated without respect to pre-retirement death, termination or disability. Earnings on deferred compensation are not reflected in this column because we do not provide above market or guarantee returns on non-qualified deferred compensation.

(4) Other annual compensation consists of the following:

Name	Vehicles Allowance	Sick Leave & Vacation Paid[a]	Other
Ramón M. Ruiz	$ 18,322	$ 54,546	—
Juan José Román	—	21,474	—
Socorro Rivas	19,847	43,234	4,514
Eva Salgado	13,826	14,976	—
Luis A. Marini	15,692	21,725	3,365

(a)

We pay to all of its employees, including the Named Executive Officers, 90% of the sick leave license days not used during the year and the excess, if any, of vacation accrued over thirty days. Amounts included represent cash paid during 2006.

Grants of Plan-Based Awards

The following table outlines the non-equity incentive awards:

		Estimated Possible Payouts Under Non-Equity Incentive Plan Awards[1]		
Name	**Grant Date**	**Threshold**	**Target**	**Maximum**
Ramón M. Ruiz	January 24, 2006	$ 275,673	$ 344,590	$ 516,888
Juan José Román	January 24, 2006	114,000	142,500	213,750
Socorro Rivas	January 24, 2006	213,080	266,350	399,525
Eva Salgado	January 24, 2006	148,120	185,150	277,725
Luis A. Marini	January 24, 2006	98,428	123,035	184,553

(1) In December 2005 the board of directors established the performance measures for purposes of determining the amounts payable for the year ended December 31, 2006. The amounts shown under the Threshold column assume that the lowest levels meet by the Company or business unit. The amount of the annual bonus can be zero if the lowest level is not achieved. Awards, if any, under this plan are payable in first quarter of the following year. Actual amounts paid for 2006 are reflected in the Summary Compensation Table — Non-Equity Incentive Plan Compensation column.

Defined Benefit Retirement Plan

The following table illustrates the present value of accumulated benefits and the number of years credited service for the Named Executive Officers under our Non-Contributory Retirement Program and Triple-S Management Corporation Supplemental Retirement Program.

PENSION BENEFITS TABLE

Name	Plan Name	Number of Years Credited Service	Present Value of Accumulated Benefit	Payments During Last Fiscal Year
Ramón Ruiz	Non-contributory Retirement Program for Certain Employees of Triple-S Management Corporation	16.50	$ 365,000	—
	Triple-S Management Corporation Supplemental Retirement Program		435,000	
Juan José Román	Non-contributory Retirement Program for Certain Employees of Triple-S Management Corporation	10.98	140,000	—
	Triple-S Management Corporation Supplemental Retirement Program		20,000	
Socorro Rivas	Non-contributory Retirement Program for Certain Employees of Triple-S Management Corporation	24.97	920,000	—
	Triple-S Management Corporation Supplemental Retirement Program		655,000	
Eva Salgado	Non-contributory Retirement Program for Certain Employees of Triple-S Management Corporation	9.89	200,000	—
	Triple-S Management Corporation Supplemental Retirement Program		31,000	
Luis A. Marini	Non-contributory Retirement Program for Certain Employees of Triple-S Management Corporation	8.91	300,000	—
	Triple-S Management Corporation Supplemental Retirement Program		6,000	

We sponsor a Non-Contributory Retirement Program for certain of our employees. The compensation covered by the pension plans is the annual salary as set forth in the Summary Compensation Table. We also have a Supplemental Retirement Program. This program covers benefits in excess of the Internal Revenue Service (IRS) limits that apply to the Non-Contributory Retirement Program, which is a qualified program under IRS rules. The following is a summary

of the pension plans' provisions.

Non-Contributory Defined-Benefit Pension Plan

- Employees eligible for participation— Employees age 21 or older with one year of service with a Blue Cross and/or Blue Shield organization are eligible to participate. An employee becomes a Participant on the January 1 or July 1 coincident with or next following the completion of the age and service participation requirements.

Employees of a subsidiary that participates in this Program are treated as employees of the Sponsoring Employer for purposes of this Program.

- Average earnings— Highest average annual rate of pay from any five consecutive calendar year periods out of the last ten years. Each year's earnings are limited to $200,000 (as indexed). As permitted under the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), for purposes of calculating Final

Average Earnings for participants who are employed on or after January 1, 2002, the $200,000 limit applied retroactively to the 1994 Program year. For 2006, the pension earnings are limited to $220,000.

- Accrued benefit— Single life benefit equal to the following:

- 2% of Final Average Earnings multiplied by Plan and Association Service (defined as years worked by an employee working with the BCBSA)

- up to 30 years, minus

- Prior Plan benefit (if any)

The Accrued Benefit cannot be less than the benefit calculated considering Employer Service only.

- Normal retirement

- Eligibility— Termination of employment after both the attainment of age 65 and after either the fifth anniversary of Program participation or completion of five years of Vesting Service.

- Benefit— The Accrued Benefit payable at Normal Retirement Date.

To be eligible for early retirement, termination of employment should occur after attaining age 55 with five years of Plan Service. The benefit will be the Accrued Benefit at Normal Retirement Date reduced using factors that are actuarially equivalent to the age 62 benefit. There is no reduction if retirement occurs after age 62.

The Plan also has a special early retirement. To be eligible, the termination of employment should occur after attaining 30 years of Plan Service and election of immediate benefit commencement. The Accrued Benefit is calculated at date of termination with no early retirement reductions. This benefit replaces the Early Retirement benefit for those meeting the Special Early Retirement benefit eligibility.

- Forms of payment— The normal form is a straight life annuity. The automatic form of payment for a single Participant is the normal form, and for a married Participant at the benefit commencement date there is a reduced qualified joint and survivor annuity, with 50% of the benefit continuing to the surviving spouse upon the earlier death of the Participant.

In lieu of the automatic form of payment, a Participant may elect, with the proper spousal consent, one of the optional forms of annuity payment or, alternatively, a single lump sum payment.

Supplementary Retirement Plan

- Employees eligible for participation— Employees with Qualified Retirement Program (the Non-Contributory Retirement Program) benefits limited by the IRC maximum compensation and benefit limits are eligible to participate.

- Final average earnings— The highest average annual rate of pay from any five consecutive calendar year periods out of the last ten years.

- Accrued benefit— Single life benefit equal to the following:

- 2% of Final Average Earnings multiplied by Plan and Association Service up to 30 years, minus

- Prior Plan benefit (if any), minus
- Qualified Retirement Program Benefit

The Accrued Benefit cannot be less than the benefit calculated considering Employer Service only.

- Normal retirement

- Eligibility— Termination of employment after both the attainment of age 65 and after either the fifth anniversary of Program participation or completion of five years of Vesting Service.

- Benefit — The Accrued Benefit payable at Normal Retirement Date.

- Early retirement

- Eligibility— Termination of employment after attaining age 55 with five years of Plan and Association Service.

- Benefit— The Accrued Benefit at Normal Retirement Date reduced using factors that are actuarially equivalent to the age 62 benefit. No reduction if retirement occurs after age 62.

- Special early retirement

- Eligibility— Termination of employment after attaining 30 years of Plan and Association Service and election of immediate benefit commencement.

- Benefit— This benefit replaces the Early Retirement benefit for those meeting the Special Early Retirement benefit eligibility.

- Forms of payment— The normal form is a straight life annuity. The automatic form of payment for a single Participant is the normal form and for a married Participant at the benefit commencement date is a reduced qualified joint and survivor annuity, with 50% of the benefit continuing to the surviving spouse upon the earlier death of the Participant.

Non-Qualified Deferred Compensation Table

The following table presents the non-qualified deferred compensation for the Named Executive Officers:

Name	Executive Contribution Last Fiscal Year	Registrant Contribution in Last Fiscal Year	Aggregate Earnings in Last Fiscal Year	Aggregate Withdrawals/ Distributions	Aggregate Balance at Last Fiscal Year
Ramón M. Ruiz	$ 13,200	—$	10,536	$ (12,028)	$ 228,528
Juan José Román	20,500	—	3,316	(4,248)	80,706
Socorro Rivas-Rodriguez	16,644	—	49,637	(55,634)	1,057,038
Eva Salgado	—	—	—	—	—
Luis A. Marini	30,000	—	11,511	(13,512)	256,729

Participants may elect to defer up to twenty percent (20%) of gross annual cash compensation under the Program. They forfeit all rights to the compensation deferred until the occurrence of any of the following events:

- Upon termination of employment

- Retirement

- Six (6) months of continued disability

- Death of Participant

- An elected fixed date occurring after the 5th but not later than the 25th anniversary of deferral

2007 Incentive Plan

The following is a summary of the Triple-S 2007 Incentive Plan (which we refer to as the Plan), under which we will be able to grant equity-based and other awards.

Plan Term. The Plan will have a 10-year term, subject to earlier termination by our board.

Authorized Shares. Subject to adjustment, up to of outstanding shares post-IPO shares of our common stock will be available for awards to be granted under the Plan. No participant in the Plan may receive stock options and stock appreciation rights in any that relate to more than shares of our common stock. Shares of common stock to be issued under the Plan may be made available from authorized but unissued common stock or common stock that we acquire.

If an award (other than a substitute award as defined below) terminates, is forfeited, cancelled or settled for cash then the shares covered by such award will again be available for issuance under the Plan. In addition, shares tendered or withheld in payment of an exercise price or for withholding taxes also will again be available for issuance under the Plan. Shares of our common stock underlying substitute awards shall not reduce the number of such shares available for delivery under the Plan. A "substitute award" is any award granted in assumption of, or in substitution for, an outstanding award previously granted by a company acquired by us or with which we combine.

Administration. Our Compensation Committee will administer the Plan and will have authority to select individuals to whom awards are granted, determine the types of awards and number of shares covered, and determine the terms and conditions of awards, including the applicable vesting schedule, performance conditions, and whether the award will be settled in cash, shares or a combination of the two.

Types of Awards. The Plan will provide for grants of incentive stock options, non-qualified stock options, stock appreciation rights, restricted stock, deferred shares, performance awards, including cash bonus awards, and other stock-based awards.

- *Stock options*. An option is the right to purchase shares of common stock at a future date at a specified exercise price. The per share exercise price of options will be determined by the Committee but may not be less than the closing price of a share of our common stock on the date of grant (other than a substitute award). The Committee determines the date after which options may be exercised in whole or in part, and the expiration date of each option. However, no option award will be exercisable after the expiration of 10 years from the date the option is granted.

- *Stock appreciation rights*. A stock appreciation right is a contractual right granted to the participant to receive, in cash or shares, an amount equal to the appreciation of one share of common stock from the date of grant. Any stock appreciation rights will be granted subject to the same terms and conditions applicable to options, as described above.

- *Restricted stock/restricted stock units*. Shares of restricted stock are shares of our common stock subject to restrictions on transfer and a substantial risk of forfeiture. A restricted stock unit consists of a contractual right denominated in shares of our common stock which represents the right to receive the value of a share of common stock at a future date, subject to certain vesting and other restrictions. While these awards generally will provide at least a 3-year vesting period if vesting is based on continued employment (1 year if based on achievement of performance objectives), restricted stock and restricted stock units will be subject to restrictions and such other terms and conditions as the Compensation Committee may determine, which restrictions and such other terms and conditions may lapse separately or in combination at such time or times, in such installments or otherwise, as the Compensation Committee may deem appropriate.

- *Deferred shares*. An award of deferred shares entitles the participant to receive shares of our common stock upon the expiration of a specified deferral period. In addition, deferred shares may be subject to restrictions on transferability, forfeiture and other restrictions as determined by the Compensation Committee.

- *Other awards*: The Compensation Committee is authorized to grant other stock-based awards, either alone or in addition to other awards granted under the Plan. Other awards may be settled in shares, cash, awards granted under the Plan or any other form of property as the Compensation Committee determines.

Eligibility. All our employees and members of our board of directors will be eligible to participate in the Plan.

Adjustments. The Compensation Committee shall adjust the terms of any outstanding awards and the number of shares of common stock issuable under the Plan for any change in shares of our common stock resulting from a stock split, reverse stock split, stock dividend, spin-off, combination or reclassification of our common stock, or any other event that affects our capitalization if the Compensation Committee determines an adjustment is equitable or appropriate.

Performance Awards. The Plan will provide that grants of performance awards, including cash-denominated awards and (if determined by the Compensation Committee) restricted stock, restricted stock units or other stock-based awards, will be made based upon, and subject to achieving, certain "performance objectives." Performance objectives with respect to those awards that are intended to qualify as "performance-based compensation" for purposes of Section 162(m) of the Internal Revenue Code are limited to premiums earned; net sales; revenue; revenue growth or product revenue growth; operating income (before or after taxes); pre- or after-tax income (before or after allocation of corporate overhead and bonus); net earnings; earnings per share; net income (before or after taxes); return on equity; total shareholder return; return on assets or net assets; appreciation in and/or maintenance of share price; market share; gross profits; earnings (including earnings before taxes, earnings before interest and taxes or earnings before interest, taxes, depreciation and amortization); economic value-added models or equivalent metrics; comparisons with various stock market indices; reductions in costs; cash flow or cash flow per share (before or after dividends); return on capital (including return on total capital or return on invested capital); cash flow return on investment; improvement in or attainment of expense levels or working capital levels; operating margins, gross margins, net margin or cash margin; year-end cash; debt reductions; shareholder equity; market share; regulatory achievements; and implementation, completion or attainment of measurable objectives with respect to research, development, products or projects and recruiting and maintaining personnel. The maximum number of shares of our common stock subject to a performance award in any fiscal year is shares and the maximum amount that can be earned in respect of a performance award denominated in cash or value other than shares on an annualized basis is $ million.

Termination of Service and Change in Control. The Compensation Committee will determine the effect of a termination of employment and a change in control (as defined in the Plan) or service on awards granted under the Plan.

Amendment, Modification and Termination. Our board may from time to time suspend, discontinue, revise or amend the Plan and the Compensation Committee may amend the terms of any award in any respect, provided that no such action will adversely impair or affect the rights of a holder of an outstanding award under the Plan without the holder's consent, and no such action will be taken without shareholder approval, if required by the rules of the stock exchange on which our shares are traded.

CERTAIN RELATIONSHIPS AND RELATED PARTY TRANSACTIONS

Certain of our directors and executive officers have immediate family members who are employed by us or our subsidiaries. The compensation of these family members is established in accordance with the employment and compensation practices applicable to employees with equivalent qualifications and responsibilities and holding similar positions.

In the ordinary course of business, our subsidiaries provide insurance to a number of our individual directors and executive officers, to the medical practices of such directors, and to members of their respective immediate families. Our subsidiaries also provide insurance to *Méndez & Co., Inc., Clínica Las Américas Guaynabo, Palmas del Mar Properties, Inc., Pan Pepin (a wholly owned subsidiary of B Fernandez & Hermanos Holding), Vernet, Inc.* and *Kevane Grant Thorton*, *LLP*. Certain directors and nominees have material ownership interests in or occupy senior positions at these entities, including as President and Director. The aggregate amount paid to our subsidiaries for services to these entities in 2006 amounted to approximately $3,700,000. The terms on which we provide insurance to related parties are substantially the same as the terms offered to unrelated parties.

Some of our directors are also service providers of Triple-S, Inc. in the ordinary course of their business as physicians and dentists. Some of our directors, their immediate family members and affiliated entities received more than $120,000 in compensation for services as healthcare providers for one of our subsidiaries. Dr. Wilmer Rodríguez-Silva, chairman of the board of directors, received approximately $147,300 and Dr. Porfirio Díaz-Torres and members of his immediate family received approximately $407,300 in 2006. *Clínica Las Américas Guaynabo,* a medical clinic of which Dr. Arturo Córdova-López is Medical Director and a principal shareholder, received total payments from TSI of approximately $1,593,000 in 2006. San Jorge Children's Medical Specialties, a medical group of which Dr. Luis A. Clavell-Rodríguez is the managing partner and controlling shareholder, received total payments from TSI of approximately $534,930 in 2006. San Jorge Children's Hospital, a hospital at which Dr. Luis A. Clavell-Rodríguez is the Chief Medical Officer, received total payments from TSI of approximately $12,776,500 in 2006. The terms of the provider agreements with Triple-S, Inc. pursuant to which the above payments were made are the same as the terms of the provider agreements of physicians and healthcare organizations who are not directors or affiliated with directors.

While we periodically monitor transactions with related persons, we have not adopted a formal written policy regarding the review, approval or ratification of transactions with related persons. On an annual basis, each of our directors and executive officers is obligated to complete a Director and Officer Questionnaire that requires disclosure of any transactions with us in which the director or executive officer, or any member of his or her immediate family, have a direct or indirect material interest.

PRINCIPAL AND SELLING SHAREHOLDERS

As of March 29, 2007, there is no person, persons, entity or entities which, by itself or as a group, as these terms are defined in Section 13(d)(3) of the Securities Exchange Act of 1934, as amended, are beneficial owners of five percent (5%) or more of the shares of our common stock.

As of March 29, 2006, we had 26,739,000 shares of common stock outstanding, giving effect to the 3,000-for-one stock split to be effected by us on May 1, 2007. Prior to the adoption of our amended and restated articles of incorporation (the articles), which became effective on February 21, 2007, the ownership of our common stock by persons that were not physicians, dentists or certain limited healthcare institutions was prohibited and no shareholder was permitted to own more than 63,000 shares of our common stock, giving effect to the 3,000-for-one stock split to be effected by us on May 1, 2007, or 5% or more of our shares of common stock. The articles eliminated the requirement that our shareholders be physicians, dentists or certain limited healthcare institutions, and replaced the numerical ownership limitation with the less restrictive limitations described in “Description of Capital Stock — Limitations on Ownership of Common Stock in our Articles.”

Stock Ownership Of Directors And Executive Officers

Beneficial ownership is determined according to the rules of the SEC, and generally means that a person has beneficial ownership of a security if he or she possesses sole or shared voting or investment power of that security, and includes options that are currently exercisable or exercisable within 60 days. The following table shows the beneficial ownership of our common stock by our directors and certain executive officers as of March 29, 2007, and the number of shares beneficially owned by all directors and executive officers as a group:

Name and Position	Amount and Nature of Beneficial Ownership[1]	Percent of Class[1]
Wilmer Rodríguez-Silva, MD, Chairman of the Board	45,000	‡
Mario S Belaval[*], Vice-Chairman of the Board[D]	3,000	‡
José Arturo Álvarez-Gallardo[*], Director	3,000	‡
Valeriano Alicea-Cruz, MD, Director	6,000	‡
Luis A. Clavell-Rodríguez, MD, Director	51,000	‡
Arturo R. Córdova-López, MD, Director	3,000	‡
Carmen Ana Culpeper-Ramírez[*], Director	3,000	‡
Porfirio E. Díaz-Torres, MD, Director	9,000	‡
Antonio F. Faría-Soto, Nominee[à]	0	‡
Manuel Figueroa-Collazo, PE, PhD[*], Director	3,000	‡
José Hawayek-Alemañy, MD, Director	30,000	‡
Vicente J. León-Irizarry, CPA[*], Director	3,000	‡
Wilfredo López-Hernández, MD, Director	6,000	‡
Jaime Morgan-Stubbe, Esq., Nominee[à]	0	‡
Roberto Muñoz-Zayas, MD, Nominee[à]	63,000	‡
Miguel A. Nazario-Franco[*], Director	3,000	‡
Juan E. Rodríguez-Díaz, Esq.[*], Director	3,000	‡
Jesús R. Sánchez-Colón, DMD, Director	3,000	‡
Adamina Soto-Martínez, CPA[*], Director	3,000	‡
Manuel Suárez-Méndez, PE[*], Director[D]	3,000	‡
Fernando J. Ysern-Borras, MD, Director[D]	3,000	‡
	3,000	‡

Ramón M. Ruiz-Comas, CPA*†, President, Chief Executive Officer, and Director		
Arturo Carrión-Crespo, CPA, Executive Officer	0	‡
Luis A. Marini-Mir, DMD, Executive Officer	3,000	‡
Roberto Morales-Tirado, Esq., Executive Officer	0	‡
Socorro Rivas-Rodríguez, CPA, Executive Officer	0	‡
Juan Jose Rodríguez-Gilibertys, Esq., Executive Officer	0	‡
Juan J. Román-Jiménez, CPA, Executive Officer	0	‡
Eva G. Salgado-Micheo, Executive Officer	0	‡
Carlos Torres-Diaz, Executive Officer	0	‡
All our directors, nominees and executive officers as a group (30 persons)	252,000	‡

[1] After giving effect to the 3,000-for-one stock split to be effected by us on May 1, 2007.

D Mr. Belaval, Mr. Suárez Méndez and Dr. Ysern-Borrás' third and final term as members of the board of directors expire on April 29, 2007, the date of the 2007 annual meeting of shareholders.

* These persons are directors representing the community (as required by our BCBSA licenses) and received one qualifying share of common stock in order to comply with the requirements in our bylaws. Shares will be returned when the director leaves the board, or when we so request.

à Antonio F. Faría-Soto, Jaime Morgan-Stubbe, and Roberto Muñoz-Zayas are nominees for the vacancies on the board of directors.

† CPA Ramón M. Ruiz-Comas is the President and Chief Executive Officer. Pursuant to our articles and bylaws, the President must be a member of the board of directors as long as such person is serving as President.

‡ Less than one percent.

Selling shareholders

The following table contains information with respect to the beneficial ownership of our common stock by the selling shareholders immediately prior to the completion of this offering and as adjusted to reflect the sale of the shares of common stock pursuant to this offering. To our knowledge, the selling shareholders have sole voting and investment power with respect to their shares of common stock listed.

			Shares of Common Stock Beneficially Owned before this Offering		**Shares of Common Stock Sold in this Offering**	**Shares of Common Stock Beneficially Owned after this Offering**	
Last Name	**First Name**	**MI**	**Number**	**Percentage**	**Number**	**Number**	**Percentage**

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DESCRIPTION OF CAPITAL STOCK

The following description of capital stock reflects our articles of incorporation and bylaws as they are expected to be amended upon the completion of this offering. Our shareholders have not yet approved such amendments.

Our articles will provide that, upon completion of this offering, we will have two classes of common stock: Class A common stock and Class B common stock. Except for the conversion provision applicable to Class A shares as described under "— Description of Common Stock — Conversion" below and the anti-dilution rights of the Class B shareholders, as described under "— Anti-Dilution Rights" below, the rights of the two classes of common stock will be identical. Class A shares will not be listed on the New York Stock Exchange, although they may under some circumstances be converted into Class B common stock.

Our authorized capital stock consists of 100,000,000 shares of common stock, $1.00 par value per share, and 100,000,000 shares of preferred stock, $1.00 par value per share. Immediately following the consummation of this offering, our authorized common stock will be divided into two classes, which will consist of

- shares designated as Class A common stock, and
- shares designated as Class B common stock.

As of March 31, 2007, we had outstanding 8,913 shares of common stock, or 26,739,000 shares giving effect to the 3,000-for-one stock split to be effected by us on May 1, 2007. These shares were held of record by 1,783 shareholders. All of these shares will become Class A shares upon consummation of this offering, with the exception of those shares sold in this offering, which will become Class B shares at that time. We expect that all shares issued by us in this offering and in the future, including pursuant to our equity compensation plan, will be Class B shares, however, we intend that any shares issued by us in respect of the possible claims described below under "— Anti-Dilution Rights" will be Class A shares. As discussed under "— Description of Common Stock — Conversion" below, subject to the approval of our board of directors, some of the remaining Class A shares may be converted into Class B shares after 12 months from completion of this offering and the remainder on the date that is five years from the completion of this offering (or earlier under limited circumstances). There were no shares of preferred stock outstanding as of March 31, 2007.

We refer you to our articles and bylaws, both of which have been filed as exhibits to the registration statement of which this prospectus forms a part, and the applicable provisions of the PRGCL.

Certain provisions of Puerto Rico law and our articles and bylaws discussed below could make it more difficult to acquire our company by means of a tender offer, a proxy contest or otherwise or to effect other change in our management. It is possible that these provisions could make it more difficult to accomplish or could deter transactions that shareholders may otherwise consider to be in their best interests or our best interests.

Anti-dilution Rights

As described under "Risk Factors — Certain of our current and former providers may bring materially dilutive claims against us" and "Risk Factors — Heirs of certain of our former shareholders may bring materially dilutive claims against us," we may be subject to claims by providers who entered into share acquisition agreements with us and/or by certain heirs of former shareholders. These claimants may seek to require us to issue shares of TSM or our managed care subsidiary, TSI, at a discount to market value. Management believes we should prevail in litigation if any judicial claims are commenced with respect to these matters; however, we cannot predict the outcome of any such litigation, including with respect to the magnitude of any claims that may be asserted by any plaintiff, and the interests of our shareholders could be materially diluted to the extent that any of these potential claims is successful.

In order to seek to protect purchasers of common stock in this offering from the potentially dilutive effect of any such issuance of shares at a discount to market value, we have adopted a dual class structure for our common stock, which will take effect upon consummation of this offering. The purpose of the dual class structure is to minimize the dilution risk to the Class B holders arising out of such an issuance.

Upon the issuance of any share of TSM (a “claimant share”) for a purchase price of less than the closing sales price of the Class B shares on the NYSE on the trading day next preceding the first public announcement that such

claimant share would be issued (i) with respect to a claim against us under any share acquisition agreement or (ii) to any purported heir of a TSM shareholder whose shares were cancelled following the holder's death prior to February 21, 2007, in respect of any purported right of such heir to receive shares owned by such shareholder at the time of his or her death, each holder of a Class B share immediately prior to such issuance (an "original Class B share") shall be entitled to receive as a distribution from us such number of newly-issued or treasury Class B shares as is necessary to maintain ownership of the approximate market value of TSM represented by the original Class B share immediately prior to the first public announcement of the planned issuance of the claimant share.

The number of new or treasury Class B shares issued in respect of each share of Class B stock outstanding immediately prior to such issuance of claimant shares shall be determined according to the following formula:

$$DR = \frac{(CAO + X)}{(CAO + Y)}$$

Where:

DR = the number of new or treasury shares of Class B common stock that will be issued for every one share of Class B common stock outstanding immediately prior to the applicable issuance of claimant shares;

CAO = the number of shares of Class A common stock outstanding immediately prior to the date on which such claimant shares are issued;

X = the aggregate number of such claimant shares issued; and

Y = the number of shares of common stock equal to the quotient of (a) the aggregate consideration paid for such claimant shares and (b) the average of the closing sale prices of TSM Class B shares on the NYSE for the 10 consecutive trading days ending on the business day immediately preceding the date on which the planned issuance of the claimant shares was first publicly announced.

For purposes of the foregoing, the board of directors of TSM shall determine in its sole discretion (i) the date of first public announcement of any issuance of a claimant share, (ii) whether claimant shares were issued for less than the applicable closing sales price of TSM Class B shares, and (iii) the value of the consideration paid, other than cash, in respect of claimant shares issued.

It is our expectation and assumption that any claimant shares issued shall be Class A shares; however, there can be no assurance that claimants will not seek and obtain Class B shares. See "Risk Factors - The dual class structure may not successfully protect against significant dilution of your Class B shares."

Upon the issuance of any share of TSI (a "TSI claimant share") for a purchase price of less than the fair value of such share with respect to a claim against TSI under any share acquisition agreement, each holder of a Class B share immediately prior to such issuance (a "pre-TSI issuance Class B share") shall be entitled to receive as a distribution from us such number of newly-issued or treasury Class B shares as is necessary to maintain the fair value of the proportional indirect ownership of TSI represented by the pre-TSI issuance Class B share immediately prior to the first public announcement of the planned issuance of the TSI claimant share.

The number of new or treasury Class B shares issued in respect of each pre-TSI issuance Class B share shall be determined according to the following formula:

$$X = \frac{OA\ (MC - VA)}{OB\ (VA - VO)}$$

Where:

X = the number of Class B shares a holder of one pre-TSI issuance Class B share would be entitled to hold following the issuance of one or more TSI claimant shares;

OA= the number of Class A shares outstanding immediately prior to such issuance;

OB = the number of Class B shares outstanding immediately prior to such issuance;

MC = the market capitalization of TSM immediately prior to the first public announcement of such issuance;

VA = MC multiplied by the percentage of TSM's common share capital represented by the Class A shares; and

VO = the difference between the fair value of the TSI claimant shares issued and the total consideration paid for such TSI claimant shares.

For purposes of the foregoing, the board of directors of TSM shall determine the value of VO in its sole discretion.

If the number of shares issued in respect of claims at the TSI level dilutes TSM's interest in TSI to a percentage lower than the percentage ownership of TSM held by the Class A shareholders, we may be unable to prevent dilution of the value of the Class B shareholders' ownership interest in TSM.

Any fractional Class B shares resulting from any issuance of shares pursuant to the anti-dilution rights of the Class B shares shall be aggregated with all other fractional shares resulting from the issuance of shares pursuant to such rights on the same day and sold on the open market by the transfer agent. The proceeds of such sale will be distributed to the holders of the original Class B shares or pre-TSI issuance Class B shares, as the case may be, in proportion to such holders' respective ownership levels on that date.

There can be no assurance that these provisions will successfully protect holders of Class B shares from the material dilution that may result from the potential claims to which we may become subject. For a description of the risks and limitations of the dual class structure, see "Risk Factors - The dual class structure may not successfully protect against significant dilution of your Class B shares."

Description of Common Stock

Holders of our common stock do not have any preemptive rights to become subscribers or purchasers of additional shares of any class of our capital stock. The rights and preferences of holders of our common stock will be junior to the rights of holders of any series of preferred stock that we may designate and issue in the future.

Voting Rights. Each share of common stock is entitled to one vote on every matter properly submitted to the shareholders for their vote. There shall be no cumulative voting of a class or series of capital stock in the election of our directors.

Dividends. Subject to the preferential rights, if any, of holders of any outstanding shares of preferred stock, the holders of common stock will be entitled to receive ratably such dividends, if any, as the board of directors may declare on the common stock out of funds legally available for that purpose.

Conversion. At any time starting on the date that is 12 months from the completion of this offering, shares of Class A common stock may be converted to Class B common stock upon approval by our board of directors, which may require that conversion occur only upon the sale of such shares in an underwritten secondary offering. The number of shares of Class A common stock that may be so converted shall be limited to the difference between 17,826,000 and the number of shares of Class A common stock sold pursuant to this offering. Beginning five years after completion of this offering, or on any earlier date that the board of directors shall determine that there are no remaining potential claims that could give rise to a right to receive shares under the Class B anti-dilution rights, any remaining Class A shares may, subject to approval of the board of directors, be converted to Class B shares, at which time the

anti-dilution protections described under "— Anti-Dilution Rights" will terminate. Our Class B common stock is not convertible into any other shares of our capital stock.

Restrictions on Transfer. Pursuant to agreements with of our Class A shareholders, until the one year anniversary of this offering, shares of our Class A common stock will not be transferable except by gift, devise or intestate succession. We may require the delivery of a legal opinion that any such proposed transfer complies with such agreements.

Liquidation. Subject to the preferential rights, if any, of any outstanding shares of preferred stock, upon our liquidation, dissolution or winding up, holders of common stock are entitled to share ratably in that portion of our assets that shall be available for distribution to the holders of such class or series.

Special Meetings of Shareholders. Special meetings of our shareholders may be called by the Chairman of the board, a majority of the board of directors, or shareholders who hold 25% of the registered voting shares.

Advance Notice Requirements for Shareholder Proposals Other than Nomination of Directors. Our bylaws provide that shareholders must deliver a written notice to our corporate secretary regarding proposals to be voted on by the shareholders (i) in the case of an annual meeting, not later than 120 days nor earlier than 150 days prior to the first anniversary of the preceding year's annual meeting; provided that if the date of the annual meeting is more than 30 days before or more than 60 days after this anniversary date, the proposing shareholder must deliver the notice not later than the 10th day following the day on which we announce the date of the annual meeting, or (ii) in the case of a special meeting of shareholders, not earlier than 150 days prior to such special meeting and not later than the later of 120 days prior to such special meeting or the 10th day following the day on which we announce the date of the special meeting.

Advance Notice Requirements for Director Nominations. Our bylaws provide that in order for an individual who is not nominated for election as a director by the nominations committee of our board of directors to be a qualified candidate:

- the individual must be nominated for an election to be held at an annual meeting of shareholders or a special meeting of shareholders held for the purpose of electing directors;

- the individual must be nominated by a shareholder of record on the record date for the meeting; and

- the nominating shareholder must have written notice delivered to or mailed and received at our principal executive offices (i) in the case of an annual meeting, not later than 120 days nor earlier than 150 days prior to the first anniversary of the preceding year's annual meeting; provided that if the date of the annual meeting is more than 30 days before or more than 60 days after this anniversary date, the proposing shareholder must deliver the notice not later than the 10th day following the day on which we announce the date of the annual meeting, or (ii) in the case of a special meeting of shareholders, not earlier than 150 days prior to such special meeting and not later than the later of 120 days prior to such special meeting or the 10th day following the day on which we announce the date of the special meeting.

Amendments; BCBSA Approval Requirement. Our board of directors shall have the power to amend our bylaws by the vote of a majority of the whole board of directors. Our shareholders shall have the power to amend our bylaws by the vote of at least a majority of the holders of the then issued and outstanding shares of capital stock entitled to vote thereon. Notwithstanding anything contained in the bylaws to the contrary, the approval of the BCBSA (unless each and every License Agreement with BCBSA to which we shall be subject shall have been terminated) shall be required to amend (i) the prohibition on cumulative voting in the election of directors, (ii) the requirement that directors comply with BCBSA rules, (iii) the requirement that the members of certain committees not be employees of us or our subsidiaries as required by BCBSA, (iv) the provision that failure to comply with BCBSA rules will be considered just cause for the removal of a director and (v) this approval requirement. The term "whole board of directors" means the total number of Directors which we would have as of the date of such determination if the board

of directors had no vacancies.

Cumulative Voting. Our articles and bylaws prohibit cumulative voting for the election of directors.

Board of Directors

Classification. Our board of directors is divided into three classes serving staggered three year terms. See "Management — Composition of the Board of Directors."

Limitations on Ownership of Common Stock in our Articles

Our license agreements with BCBSA require, as a condition to our retention of the licenses, that our articles contain certain provisions, including limitations on the ownership of our common stock. Our articles provide that no person may beneficially own shares of our voting capital stock in excess of the specified BCBSA ownership limit (the BCBSA ownership limit). The BCBSA ownership limit, which may not be exceeded without prior approval of the BCBSA, is the following:

- for any "Institutional Investor", one share less than 10% of our outstanding voting securities;
- for any "Noninstitutional Investor", one share less than 5% of our outstanding voting securities; and
- for any person, one share less than 20% of the number of shares of common stock issued or outstanding or any combination of shares that represents 20% or more of the ownership interest in our company.

"Institutional Investor" means any person if (but only if) such person is identified in Rule l3d-l(b)(l)(ii) under the Exchange Act, provided that every filing made by such person with the SEC under Regulation 13D-G (or any successor Regulation) under the Exchange Act with respect to such person's beneficial ownership of capital stock by such person shall have contained a certification identical to the one required by Item 10 of Schedule 13G, or such other affirmation as shall be approved by the BCBSA and the board of directors.

"Noninstitutional Investor" means any person that is not an Institutional Investor.

Any transfer of stock that would result in any person beneficially owning shares of capital stock in excess of the ownership limit will result in the intended transferee acquiring no rights in such shares (with certain exceptions) and the person's shares will be deemed transferred to an escrow agent to be held until the shares are transferred to a person whose ownership of shares will not violate the ownership limit. These provisions prevent a third party from obtaining control of our company without obtaining the prior approval of our continuing directors and the 75% supermajority vote of our shareholders required to amend these provisions of our articles and may have the effect of discouraging or even preventing a merger or business combination, a tender offer or similar extraordinary transaction involving us.

Limitation of Liability of Directors and Officers. Our articles provide that the personal liability of our directors for monetary damages due to breaches of their fiduciary duties will be eliminated, except for liability:

- for any breach of the director's duty of loyalty to us or our shareholders;
- for acts or omissions not in good faith or which involve intentional misconduct or a knowing violation of law;
- for an improper payment of a dividend or an improper purchase or redemption of our stock, in contravention of the PRGCL; and
- for any transaction from which the director derived an improper personal benefit.

Indemnification of Directors and Officers. The PRGCL contains detailed and comprehensive provisions providing for indemnification of directors and officers of Puerto Rico corporations against expenses, judgments, fines and settlements in connection with litigation. Under the PRGCL, such indemnification is available if it is determined that the proposed indemnitee acted in good faith and in a manner he or she reasonably believed to be in

or not opposed to our best interests and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful.

Our articles provide that every person who:

- is or was a director, officer or employee; or
- is or was a director, officer, employee or agent of any other enterprise, serving as such at our request;

will be indemnified to the fullest extent permitted by law for all expenses and liabilities in connection with any proceeding involving the person in this capacity.

Advancement of Expenses; Reimbursement of Expenses. To the extent permitted by the PRGCL, our articles provide that certain expenses incurred in defending various types of claims may be advanced by us. In addition, attorney's fees incurred by any of our directors or officers in enforcing any such person's indemnification rights will be reimbursed by us to such directors and officers if it is ultimately determined that they were entitled to indemnification by us.

Indemnification of Officers and Directors. Our articles also permit us to secure insurance on behalf of any officer, director or employee for any liability asserted against or incurred by these individuals in their capacity, or arising out of their status, regardless of whether other provisions of our articles would permit indemnification. However, we do not have to indemnify for any amounts which have been paid directly to such person by insurance maintained by us, and any indemnification provided pursuant to the indemnification section of our articles cannot be used as a source of contribution to, or as a substitute for, any indemnification obligation available from another entity. Indemnification will not be given if the amounts are covered by another indemnification obligation or by insurance coverage.

Puerto Rico Insurance Laws

For a discussion of how Puerto Rico insurance laws affect our share capital, please see "Regulation—Puerto Rico Insurance Laws."

Listing

We intend to apply to list our common stock on the NYSE under the symbol "GTS."

Transfer Agent and Registrar

Upon completion of the offering, the transfer agent and registrar for our common stock will be American Stock Transfer & Trust Company. Its address is 59 Maiden Lane, New York, New York 10038 and its telephone number at this location is (212) 936-5100.

SHARES ELIGIBLE FOR FUTURE SALE

Upon completion of this offering, we will have issued and outstanding an aggregate of shares of Class B common stock and shares of Class A common stock, assuming no exercise of the underwriters' over-allotment option. All of such shares will be freely tradable without restriction or further registration under the Securities Act, except for such Class A shares as are subject to the contractual restrictions on transfer described under "Description of Capital Stock", and except for any shares of either class held by our affiliates as that term is defined in Rule 144 under the Securities Act. We estimate that less than 1% of our shares will be held by affiliates and that approximately % of our Class A shares will be subject to such transfer restrictions upon completion of this offering. Our Class A shares will not be listed on the NYSE and are not fungible with our Class B shares. However, after the one year anniversary of this initial public offering, our board of directors may in its discretion cause up to approximately half of the Class A shares outstanding at that time to convert to Class B shares in connection with an underwritten public offering of such Class A shares.

CERTAIN UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS

U.S. Federal Income Tax Considerations

The following is a discussion of the material U.S. federal income tax considerations relevant to the acquisition, ownership and disposition of Class B shares by U.S. Holders, as defined below, but it does not purport to be a comprehensive description of all of the tax considerations that may be relevant to a particular person's decision to acquire such securities. The discussion applies only if you hold Class B shares as a capital asset for tax purposes and it does not describe all of the tax consequences that may be relevant to holders subject to special rules, such as:

- certain financial institutions;
- regulated investment companies and real estate investment trusts;
- insurance companies;
- dealers and traders in securities or foreign currencies;
- persons holding Class B shares as part of a hedge, straddle, conversion transaction or other integrated transaction;
- persons whose functional currency for U.S. federal income tax purposes is not the U.S. dollar;
- partnerships or other entities classified as partnerships for U.S. federal income tax purposes;
- persons liable for the alternative minimum tax;
- certain former residents of the United States; or
- tax-exempt organizations.

This discussion is based on the Internal Revenue Code of 1986, as amended (the "Code"), administrative pronouncements, judicial decisions and final, temporary and proposed Treasury regulations, all as of the date of this offering. These laws are subject to change, possibly on a retroactive basis. Please consult your own tax advisors concerning the U.S. federal, state, local and foreign tax consequences of purchasing, owning and disposing of Class B shares in your particular circumstances.

As used herein, the term "U.S. Holder" means a beneficial owner of Class B shares that is for U.S. federal income tax purposes:

- a citizen or resident of the United States;
- a corporation, or other entity taxable as a corporation, created or organized in or under the laws of the United States or any political subdivision thereof; or
- an estate or trust the income of which is subject to U.S. federal income taxation regardless of its source.

The term "U.S. Holder" does not include individual Puerto Rico residents who are not citizens or residents of the United States, nor does it include Puerto Rico corporations or other Puerto Rico entities taxable as corporations. As used herein, the term "Puerto Rico U.S. Holder" means an individual U.S. Holder who is a bona fide resident of Puerto Rico

during the entire taxable year (or, in some cases, a portion thereof) within the meaning of Section 933 of the Code.

Taxation of Distributions

Subject to the controlled foreign corporation rules, related person insurance income rules and passive foreign investment company rules, each described below, distributions paid on Class B shares, other than certain pro rata distributions of Class B shares (including any distributions of Class B shares in respect of anti-dilution rights, as discussed below), will be treated as a dividend to the extent paid out of current or accumulated earnings and profits (as determined under U.S. federal income tax principles). Subject to applicable limitations and the discussion below concerning Puerto Rico U.S. Holders, dividends paid to non-corporate U.S. Holders in taxable years beginning before January 1, 2011 will be taxable at a maximum rate of 15%. U.S. Holders should consult their own tax advisors regarding the implications of these rules in their particular circumstances. The amount of a dividend will include any amounts withheld by the Company or its paying agent in respect of Puerto Rico taxes. Because the Company does not currently and does not expect to conduct significant operations in the United States, the amount of the dividend generally will be treated as foreign source dividend income and will not be eligible for the dividends received deduction generally allowed to U.S. corporations under the Code.

Subject to applicable limitations that may vary depending upon your circumstances and provided that you are not a Puerto Rico U.S. Holder, any Puerto Rico taxes withheld from dividends on Class B shares will be creditable against your U.S. federal income tax liability. The limitation on foreign taxes eligible for credit is calculated separately with respect to specific classes of income. Additionally, the total amount of foreign tax credit allowable will be reduced if the Company pays a dividend and a portion of the Company's earnings and profits for such taxable year is from sources within the United States. The rules governing foreign tax credits are complex and, therefore, you should consult your own tax advisors regarding the availability of foreign tax credits in your particular circumstances. Instead of claiming a credit, you may, at your election, deduct such otherwise creditable Puerto Rico taxes in computing your taxable income, subject to generally applicable limitations under U.S. federal income tax law.

A Puerto Rico U.S. Holder generally will be exempt from U.S. federal income taxation with respect to dividends paid on Class B shares. However, in the event the Company expands its operations outside of Puerto Rico, and depending on the extent of such operations, dividends paid on Class B shares to a Puerto Rico U.S. Holder may not be eligible for the exemption. Such holders should consult their own tax advisors concerning their status as a Puerto Rico U.S. Holder, the availability of the exemption from U.S. federal income tax on dividends in their particular circumstances and certain limitations on deductions and credits that may otherwise be available under U.S. federal income tax law.

Distributions in Respect of Anti-Dilution Rights

Distributions of Class B shares, other than cash in lieu of fractional Class B shares, received as a distribution in respect of anti-dilution rights (as discussed above under "Description of Capital Stock—Anti-Dilution Rights") generally will not be subject to U.S. federal income tax on the date of distribution. In the event of such a pro rata distribution, a U.S. Holder's tax basis in the newly distributed Class B shares (including any fractional shares) (the "New Shares") and the Class B shares held before the distribution (the "Old Shares") will be determined by allocating such holder's basis in the Old Shares between the Old Shares and the New Shares in proportion to the fair market values of each on the date of distribution. A U.S. Holder will have the same holding period for the New Shares as it had for the Old Shares. With respect to any cash received in lieu of fractional Class B shares, a U.S. Holder will realize gain or loss on an amount equal to the difference between the amount of cash received and the U.S. Holder's tax basis in the fractional Class B shares, determined in the manner discussed above. Any gain or loss will be subject to U.S. federal income tax as described below under "—Sale or Other Disposition of Class B Shares."

Sale or Other Disposition of Class B Shares

Subject to the controlled foreign corporation rules, related person insurance income rules and passive foreign investment company rules, each described below, and subject to the discussion below concerning Puerto Rico U.S. Holders, for U.S. federal income tax purposes, any gain or loss you realize on the sale or other disposition of Class B

shares will be capital gain or loss, and will be long-term capital gain or loss if you held the Class B shares for more than one year. The amount of your gain or loss will be equal to the difference between the amount realized on the

disposition and your tax basis in the Class B shares disposed of. Such gain or loss generally will be U.S. source gain or loss for foreign tax credit purposes, unless you are a Puerto Rico U.S. Holder.

If any gain from the sale or other disposition of Class B shares is subject to Puerto Rico tax, you may not be able to credit such taxes against your U.S. federal income tax liability under the U.S. foreign tax credit limitations of the Code because such gain generally would be U.S. source income. However, such tax may be credited against tax due on other income derived from foreign sources (subject to applicable limitations).

Gain realized by a Puerto Rico U.S. Holder on the sale or other disposition of Class B shares generally will be exempt from U.S. federal income taxation and will be treated as Puerto Rico source income for U.S. federal income tax purposes. Such holders should consult their own tax advisors concerning their status as Puerto Rico U.S. Holders, the availability of the exemption from tax on gains from the sale or other disposition of Class B shares in their particular circumstances and certain limitations on deductions and credits that may otherwise be available under U.S. federal income tax law.

Controlled Foreign Corporation Rules

A foreign corporation generally is considered a controlled foreign corporation (a "CFC") for U.S. federal income tax purposes if 10% U.S. Shareholders (as defined below) directly, indirectly or constructively own more than 50% of such company's shares by vote or value. In addition, for purposes of taking into account certain insurance income, the term CFC also generally includes a foreign insurance company in which 10% U.S. Shareholders directly, indirectly or constructively own more than 25% of such company's shares by vote or value. A "10% U.S. Shareholder" is a U.S. person, other than a Puerto Rico U.S. Holder, who directly, indirectly or constructively owns at least 10% of the total combined voting power of all classes of stock entitled to vote of the foreign corporation.

The Company does not expect that it is currently a CFC, and, taking into account the effects of the limitations on ownership of the Company's Class B shares contained in the Company's Amended and Restated Articles of Incorporation (see "Description of Capital Stock" in this prospectus), expects that it is not likely to become a CFC. However, these existing ownership restrictions were not designed for the purpose of preventing any person from being treated as a 10% U.S. Shareholder for U.S. federal income tax purposes and, in light of the applicable ownership attribution rules imposed by the Code, there can be no assurance that the Company will not be a CFC in any taxable year. If the Company were a CFC for any taxable year, certain adverse tax consequences could apply to 10% U.S. Shareholders.

If the Company were a CFC for an uninterrupted period of 30 days or more during any taxable year of the Company, each 10% U.S. Shareholder that holds Class B shares on the last day of such year would be required to include in its gross income for U.S. federal income tax purposes such 10% U.S. Shareholder's pro rata share of the Company's "subpart F income," regardless of whether the Company made any distributions during such year. "Subpart F income" of a foreign insurance corporation typically includes, among other items, passive income such as interest and dividends, as well as insurance and reinsurance income (including underwriting and investment income) attributable to the insurance of risks situated outside the CFC's country of incorporation. In addition, upon the sale or exchange of Class B shares by any U.S. Holder who is a 10% U.S. Shareholder at any time during the 5-year period ending on the date of the sale or exchange when the Company was a CFC, any gain recognized by such a U.S. Holder may be treated as dividend income (as described above under "—Taxation of Distributions") and certain IRS filing requirements may apply.

Related Person Insurance Income Rules

In addition to the CFC rules described above, special rules apply to U.S. persons, other than Puerto Rico U.S. Holders, that hold stock in a foreign corporation that is a controlled foreign corporation under the related person insurance

income rules (a “RPII CFC”) for U.S. federal income tax purposes. The Company does not expect that it will be considered a RPII CFC. However, because RPII CFC status depends in part upon the correlation between an insurance company’s shareholders and such company’s insurance customers and the extent of such company’s insurance business outside its country of incorporation, there can be no assurance that the Company will not be a RPII CFC in any taxable year. If the Company were a RPII CFC for any taxable year, certain adverse tax consequences could apply.

Unless the Company is eligible for certain exceptions, such as the one discussed below, the Company will be considered a RPII CFC if U.S. persons, not including Puerto Rico U.S. Holders, directly or indirectly own 25% or more of the Company's shares by vote or value. If the Company were a RPII CFC, U.S. Holders, other than Puerto Rico U.S. Holders, that hold Class B shares on the last day of the Company's taxable year generally would be required to include in gross income their proportionate share of the Company's related person insurance income (or "RPII"), subject to certain limitations, regardless of whether the Company made any distributions during such year. The Company's RPII generally will be the insurance income (as defined in the Code) attributable to policies of insurance or reinsurance with respect to which the person (directly or indirectly) insured is (x) (i) a U.S. person, other than a U.S. person that is a bona fide resident of Puerto Rico, and (ii) holds (directly or indirectly) any of the Company's shares or (y) a person related to a person described in (x). Notwithstanding the exceptions to the RPII CFC rules discussed below, if U.S. persons, not including Puerto Rico U.S. Holders, directly or indirectly own 25% or more of the Company's shares by vote or value, any gain recognized by U.S. Holders, other than Puerto Rico U.S. Holders, on the sale or exchange of the Class B shares held for a period of more than one year will be treated as dividend income (as described above) to the extent of the U.S. Holder's pro rata portion of the Company's earnings and profits that were accumulated by the Company during the period such stock was held by the U.S. Holder while U.S. persons, not including Puerto Rico U.S. Holders, directly or indirectly own 25% or more of the Company's shares by vote or value. In addition, certain IRS filing requirements may apply. As the rules governing this gain recharacterization are complex, you should consult your own tax advisors regarding the application of these rules based on your particular situation.

The Company will not be a RPII CFC if it qualifies for one of the RPII CFC exceptions. For example, if the Company's RPII for a taxable year is less than 20% of the Company's gross insurance income (as determined under the Code), which, for these purposes, includes the Company's insurance income generated in Puerto Rico, then the Company will not be deemed a RPII CFC for that taxable year.

Based on the location and extent of its business operations, the Company expects that it should qualify for the exception from the RPII CFC rules discussed above and expects that it should continue to qualify for this exception to the RPII CFC rules for the foreseeable future. However, if the Company expands its operations outside of Puerto Rico, the Company could generate substantial RPII and no longer qualify for the exception to the RPII CFC rules. The Company does not intend to monitor whether or not it generates RPII or becomes a RPII CFC and can provide no assurance that it will not become a RPII CFC in the future. You are urged to consult your own tax advisors concerning the RPII CFC rules and the U.S. federal income tax consequences of the Company becoming an RPII CFC.

Passive Foreign Investment Company Rules

The Company does not expect that it will be considered a PFIC for U.S. federal income tax purposes. However, since PFIC status depends upon the composition of a company's income and assets and the market value of its assets (including, among others, less than 25 percent owned equity investments and the Company's ability to use the proceeds from this offering in a timely fashion) from time to time, there can be no assurance that the Company will not be considered a PFIC for any taxable year. The Company's belief that it is not a PFIC is based, in part, on the fact that the PFIC rules include provisions intended to provide an exception for bona fide insurance companies predominantly engaged in an insurance business. However, the scope of this exception is not entirely clear and there are no judicial decisions or Treasury regulations that provide guidance as to the application of the PFIC rules to insurance companies. If the Company were treated as a PFIC for any taxable year during which you held Class B shares, certain adverse consequences could apply.

If the Company is treated as a PFIC for any taxable year, gain recognized by a U.S. Holder on a sale or other disposition of Class B shares would be allocated ratably over the U.S. Holder's holding period for the Class B shares. The amounts allocated to the taxable year of the sale or other exchange and to any year before the Company became a PFIC would be taxed as ordinary income. The amounts allocated to each other taxable year would be subject to tax at

the highest rate in effect for individuals or corporations, as appropriate, and an interest charge would

be imposed on the amount allocated to each such taxable year. Further, any distribution in respect of Class B shares in excess of 125 percent of the average of the annual distributions on Class B shares received by the U.S. Holder during the preceding three years or the U.S. Holder's holding period, whichever is shorter, would be subject to taxation as described above. Certain elections may be available (including a mark to market election) to U.S. Holders that may mitigate the adverse consequences resulting from PFIC status. Under proposed Treasury regulations, a Puerto Rico U.S. Holder generally will only be subject to the allocation of gains and excess distributions described above to taxable years in which the individual held Class B shares and was not a bona fide resident of Puerto Rico during the entire taxable year or, in certain circumstances, a portion thereof within the meaning of Section 933 of the Code.

In addition, if the Company were to be treated as a PFIC in a taxable year in which it pays a dividend or the prior taxable year, the 15% dividend rate discussed above with respect to dividends paid to non-corporate holders would not apply.

Information Reporting and Backup Withholding

Payments of dividends and sales proceeds that are made within the United States or through certain U.S.-related financial intermediaries generally are subject to information reporting and to backup withholding unless (i) you are a corporation or other exempt recipient or (ii) in the case of backup withholding, you provide a correct taxpayer identification number and certify that you are not subject to backup withholding.

The amount of any backup withholding from a payment to you will be allowed as a credit against your U.S. federal income tax liability and may entitle you to a refund, provided that the required information is furnished to the IRS.

PUERTO RICO INCOME TAX CONSIDERATIONS

General

In the opinion of Acosta Ramirez C.S.P., our Puerto Rico tax counsel, the following discussion summarizes the material Puerto Rico tax considerations relating to the purchase, ownership and disposition of our common stock. This discussion does not describe all of the tax considerations that may be relevant to a particular investor's decision to acquire such securities and does not describe any tax consequences arising under the laws of any state, locality or taxing jurisdiction other than Puerto Rico. In addition, the following discussion does not address purchasers subject to special rules of taxation, such as life insurance companies, "Special Partnerships," "Subchapter N Corporations," registered investment companies, and certain pension trusts all as defined under Puerto Rico tax statutes.

This discussion is based on the tax laws of Puerto Rico as of this date, as well as regulations, administrative pronouncements and judicial decisions available on or before such date and now in effect. All of the foregoing is subject to change, which change could apply retroactively and could affect the continued validity of this summary. A prospective investor should be aware that an opinion of counsel represents only such counsel's best legal judgment and that it is not binding on the Puerto Rico Treasury Department, any municipality or agency of Puerto Rico, or the courts. Accordingly, there can be no assurance that the opinions set forth herein, if challenged, would be sustained.

You should consult your own tax advisor as to the application of the tax considerations discussed below to your particular situation, as well as the application of any state, local, foreign or other tax.

For purposes of the discussion below, a "Puerto Rico corporation" is a corporation organized under the laws of Puerto Rico and a "foreign corporation" is a corporation organized under the laws of a jurisdiction other than Puerto Rico. Corporations organized under the laws of the United States, the District of Columbia or any of the states, other possessions or territories of the United States are considered "foreign corporations" for Puerto Rico income tax purposes.

Ownership and Disposition of Common Stock

Taxation of Dividends

General. Distributions of cash or other property made by us on our common stock will be treated as dividends to the extent that we have current or accumulated earnings and profits. To the extent that a distribution exceeds our current and accumulated earnings and profits, the distribution will be treated as a return of capital and reduce the adjusted tax basis of the common stock in the hands of the holder. The excess of such a distribution of this type over the adjusted tax basis will be treated as gain on the sale or exchange of the common stock and will be subject to income tax as described below under "— Taxation of Gains upon Sales or Exchange other than a Redemption."

The following discussion regarding the income taxation of dividends on our common stock received by individuals not residents of Puerto Rico and foreign corporations not engaged in a trade or business in Puerto Rico assumes that dividends will constitute income from sources within Puerto Rico. Generally, a dividend declared by a Puerto Rico corporation will constitute income from sources within Puerto Rico for purposes of Puerto Rico income taxes unless the corporation derived less than 20% of its gross income from sources within Puerto Rico for the three taxable years preceding the year of the declaration. We have represented that 20% or more of our gross income has been derived from Puerto Rico sources on an annual basis since our incorporation in 1996.

Individual Residents of Puerto Rico and Puerto Rico Corporations. In general, individuals who hold our stock and are residents of Puerto Rico will be subject to a 10% income tax on dividends paid on our common stock. This tax

is generally required to be withheld by us on dividends paid on our common stock. An individual may elect for this withholding not to apply. In that case the holder will be required to include the amount of the dividend as ordinary income and will be subject to income tax thereon at the regular income tax rates, which may be up to 33%. Individuals for which the withholding is made may elect, upon filing his or her income tax return for the year the

dividend is paid, for the dividends to be taxed at the normal income tax rates applicable to individuals, in which case the 10% Puerto Rico income tax withheld is creditable against the normal tax so determined.

Puerto Rico corporations that hold our stock will be subject to income tax on dividends paid on our common stock at the regular corporate income tax rates, subject to the dividend received deduction discussed below. No withholding will be imposed on dividends paid to Puerto Rico corporations on our common stock unless such shares are held in "street name" through certain foreign financial institutions or other securities intermediaries as discussed below. The dividend received deduction will be equal to 85% of the dividend received, but the deduction may not exceed 85% of the corporation's net taxable income. Based on the applicable maximum Puerto Rico regular corporate income tax rate of 39%, effective for taxable years commencing on or after January 1st, 2007, the maximum effective income tax rate on these dividends will be 5.85% after accounting for the dividend received deduction. The applicable maximum Puerto Rico normal corporate income tax rate for a taxable year commenced during calendar year 2006 is 41.5%.

Dividends on our common stock held in "street name" through foreign financial institutions or other securities intermediaries not engaged in trade or business in Puerto Rico will generally be subject to a 10% withholding tax imposed on foreign corporations. See -"Foreign Corporations." Accordingly, individual residents of Puerto Rico holding our common stock in street name who elect out of the applicable 10% withholding tax should have their shares of common stock issued and registered in their own name. Similarly, Puerto Rico corporations that hold shares of common stock through foreign financial institutions should have their shares issued and registered in their own name to ensure that no withholding is made on dividends.

United States Citizens Not Residents of Puerto Rico. Dividends paid on our common stock to a United States citizen who is not a resident of Puerto Rico will be subject to the 10% Puerto Rico income tax, which will be withheld by us. These individuals may elect for this 10% Puerto Rico income tax and withholding not to apply. Notwithstanding the making of this election, a separate 10% withholding tax will be required on the amount of the dividend unless the individual timely files with us a withholding exemption certificate to the effect that the individual's gross income from sources within Puerto Rico during the taxable year does not exceed $1,300 if single or married not living with spouse, or $3,000 if married and living with spouse or $1,500 if married filing separately. Withholding exemption certificates will only be accepted by us through the Puerto Rico Department of the Treasury Form AS 2732, Withholding Tax Exemption Certificate in the Case of Nonresident Individuals-Citizens of the United States, or any other form issued by the Puerto Rico Department of the Treasury for these purposes and from individuals who have the shares of common stock registered in their names. Individuals for which the withholding is made may also elect, upon filing his or her income tax return for the year the dividend is paid, for the dividends to be taxed at the normal income tax rates applicable to individuals, in which case the 10% Puerto Rico income tax withheld is creditable against the normal tax so determined.

Individuals Not Citizens of the United States and Not Residents of Puerto Rico. Dividends paid on our common stock to any individual who is not a citizen of the United States and who is not a resident of Puerto Rico will generally be subject to a 10% Puerto Rico income tax, which will be withheld at source by us.

Foreign Corporations. The income taxation of dividends paid on our common stock to a foreign corporation will depend on whether or not the corporation is engaged in a trade or business in Puerto Rico in the taxable year of the dividend.

A foreign corporation that is engaged in a trade or business in Puerto Rico will be subject to the applicable regular Puerto Rico corporate income tax rates on their net income that is effectively connected with the active conduct of a trade or business in Puerto Rico. This income will include all net income from sources within Puerto Rico and certain items of net income from sources outside Puerto Rico that are effectively connected with the active conduct of a trade or business in Puerto Rico. Net income from sources within Puerto Rico will include dividends on our common stock.

A foreign corporation that is engaged in a trade or business in Puerto Rico will be entitled to claim the 85% dividend received deduction discussed above under "–Individual Residents of Puerto Rico and Puerto Rico Corporations" in connection with Puerto Rico corporations.

In general, foreign corporations that are engaged in a trade or business in Puerto Rico are also subject to a 10% branch profits tax. However, dividends on our common stock received by these corporations will be excluded from the computation of the branch profits tax liability of these corporations.

A foreign corporation that is not engaged in a trade or business in Puerto Rico will be subject to a 10% withholding tax on dividends received on our common stock, which will be withheld at source by us.

Partnerships. Partnerships are generally taxed in the same manner as corporations. Accordingly, the preceding discussion with respect to Puerto Rico and foreign corporations is equally applicable in the case of most Puerto Rico and foreign partnerships, respectively.

Taxation of Gains upon Sale or Exchange other than a Redemption

General. The sale or exchange of our common stock will give rise to gain or loss equal to the difference between the amount realized on the sale or exchange and the tax basis of the common stock in the hands of the holder. Any gain or loss that is recognized will be a capital gain or loss if the common stock is held as a capital asset by the holder and will be a long-term capital gain or loss if the shareholder has held our common stock for more than six months. The deductibility of capital losses is subject to limitations.

Individual Residents of Puerto Rico and Puerto Rico Corporations. Gain on the sale or exchange of our common stock by an individual resident of Puerto Rico or a Puerto Rico corporation generally will be recognized as gross income and subject to income tax. If the shareholder is an individual and the gain is a long-term capital gain, such gain will be taxable at a maximum rate of 12.5%, if so elected by the shareholder. If the shareholder is a Puerto Rico corporation and the gain is a long-term capital gain, the gain will be subject to Puerto Rico income tax at the lesser of 20% or the shareholder's ordinary income tax rate.

United States Citizens Not Residents of Puerto Rico. A United States citizen who is not a resident of Puerto Rico will not be subject to Puerto Rico income tax on the sale or exchange of our common stock if such gain constitutes income from sources outside Puerto Rico. Generally, gain on the sale or exchange of common stock will be considered income from sources outside Puerto Rico if all rights, title and interest in or to the common stock are transferred outside Puerto Rico, and if the delivery or surrender of the instruments that evidence the common stock is made to an office of a paying or exchange agent located outside Puerto Rico. If the gain resulting from the sale or exchange constitutes income from sources within Puerto Rico, an amount equal to 12.5% of the payments received will be withheld at the source; and if the gain constitutes a long-term capital gain, it will be subject to a tax at a maximum rate of 12.5%. The amount of tax withheld at source will be creditable against the shareholder's Puerto Rico income tax liability.

Individuals Not Citizens of the United States and Not Residents of Puerto Rico. An individual who is not a citizen of the United States and who is not a resident of Puerto Rico will be subject to the rules described above under "-United States Citizens Not Residents of Puerto Rico." However, if the gain resulting from the sale or exchange of common stock constitutes income from sources within Puerto Rico, that amount that represents a net capital gain will generally be subject to tax at a fixed rate of 29% and a withholding tax at source of 12.5%. The amount of tax withheld at source will be creditable against the shareholder's Puerto Rico income tax liability.

Foreign Corporations. A foreign corporation that is engaged in a trade or business in Puerto Rico will generally be subject to Puerto Rico corporate income tax on any gain realized on the sale or exchange of our common stock if such gain is (1) from sources within Puerto Rico or (2) from sources outside Puerto Rico (determined as described above under "-United States citizens Not Residents of Puerto Rico") and effectively connected with a trade or business in Puerto Rico. Any such gain will qualify for an alternative tax of 20% if it qualifies as a long-term capital gain.

A foreign corporation that is not engaged in a trade or business in Puerto Rico will generally be subject to a corporate income tax rate of 29% on any capital gain realized on the sale or exchange of our common stock if the gain is from sources within Puerto Rico. Gain on the sale or exchange of common stock will generally not be considered to be from sources within Puerto Rico if all rights, title and interest in or to the common stock are transferred outside Puerto Rico, and if the delivery or surrender of the instruments that evidence the common stock is made to an office of a paying or exchange agent located outside Puerto Rico. If the payments received resulting from the sale or exchange constitutes income from sources within Puerto Rico, an amount equal to 12.5% of the payments received will be

withheld at the source and be creditable against the shareholder's Puerto Rico income tax liability. In the case of such foreign corporation, no income tax will be imposed if the gain constitutes income from sources outside Puerto Rico.

In general, foreign corporations that are engaged in a trade or business in Puerto Rico will also be subject to a 10% branch profits tax. Any gain realized by these corporations on the sale or exchange of common stock and that is subject to Puerto Rico income tax will be taken into account for purposes of computing this tax. However, a deduction will be allowed in the computation for any income tax paid on the gain realized on such sale or exchange.

Partnerships. Partnerships are generally taxed as corporations. Accordingly, the discussion with respect to Puerto Rico and foreign corporations is equally applicable to most Puerto Rico and foreign partnerships, respectively.

Taxation of Redemptions

Redemption of shares of our common stock for cash will be treated as a distribution taxable as a dividend (as described above under "-Taxation of Dividends") to the extent of our current or accumulated earnings and profits and if it is "essentially equivalent to a dividend." Under regulations issued by the Department of the Treasury of Puerto Rico (1) a redemption of stock that completely terminates a stockholder's interest in a corporation does not constitute a dividend and (2) certain pro rata redemptions among all the stockholders will be treated as a dividend. In situations not described by these regulations, the Department of the Treasury of Puerto Rico will generally follow principles applied by the United States Internal Revenue Service (the "IRS") under the United States Internal Revenue Code of 1986, in determining whether a distribution is essentially equivalent to a dividend. The Department of the Treasury of Puerto Rico, however, is not bound by IRS determinations on this issue and is free to adopt a different rule.

If the redemption of our common stock is not treated as a dividend, any gain or loss that will be treated as described above under "-Taxation of Gains upon Sales or Exchanges (Not including Redemptions)" for a sale or exchange of common stock. Gain on the redemption of our common stock will generally be recognized and will be subject to income tax. If the holder of the common stock is an individual resident of Puerto Rico and the gain is a long-term capital gain, the gain should be taxable at a maximum rate of 12.5%. If the stockholder is a Puerto Rico corporation and the gain is a long-term capital gain, the gain should qualify for the alternative tax rate of 20%.

A stockholder that is an individual who is not a resident of Puerto Rico or a foreign corporation or foreign partnership should note that the Puerto Rico income tax law does not clearly provide a source of income rule for any gain of this nature. As a result, these prospective stockholders should be aware that any gain realized from redemption of our common stock may be subject to Puerto Rico income tax and withholding.

Estate and Gift Taxation

The transfer of our common stock by inheritance by an individual who is a resident of Puerto Rico at the time of his or her death will not be subject to estate tax if the individual is a citizen of the United States who acquired his or her citizenship solely by reason of birth or residence in Puerto Rico. The transfer of our common stock by gift by an individual who is a resident of Puerto Rico at the time of the gift will not be subject to gift tax. Other individuals should consult their own tax advisors in order to determine the appropriate treatment for Puerto Rico estate and gift tax purposes of the transfer of our common stock by death or gift.

Municipal License Taxation

Individuals and corporations that are not engaged in a trade or business in Puerto Rico will not be subject to municipal license tax on dividends paid on our common stock or on any gain realized on the sale, exchange or redemption of such common stock.

A corporation or partnership, Puerto Rico or foreign, that is engaged in a trade or business in Puerto Rico will generally be subject to municipal license tax on dividends paid on our common stock and the gross proceeds realized from the sale, exchange or redemption of such common stock if attributable to that trade or business. If the corporation or partnership is considered a financial business for municipal license tax purposes it will be allowed to reduce the gross proceeds from the sale of the common stock by the cost of the common stock sold in computing its municipal license tax. The municipal license tax is imposed on the volume of business of the taxpayer, and the tax rates range from a maximum of 1.5% for financial businesses to a maximum of 0.5% for other businesses.

Property Taxation

Our common stock will not be subject to Puerto Rico property tax.

UNDERWRITING

General

Under the terms and subject to the conditions contained in an underwriting agreement dated , 2007, we and the selling shareholders have agreed to sell to the underwriters named below, for whom Credit Suisse Securities (USA) LLC and UBS Securities LLC are acting as representatives, the following respective numbers of shares of common stock:

Underwriter	**Number of Shares**
Credit Suisse Securities (USA) LLC	
UBS Securities LLC	
Total	

The underwriting agreement provides that the underwriters are obligated to purchase all the shares of common stock in the offering if any are purchased, other than those shares covered by the over-allotment option described below. The underwriting agreement also provides that, in the event of a default, the purchase commitments of non-defaulting underwriters may be increased or the offering may be terminated.

We and the selling shareholders have granted to the underwriters a 30-day option to purchase up to additional shares [from us and an aggregate of additional shares from the selling shareholders on a pro rata basis] at the initial public offering price less the underwriting discounts and commissions. The option may be exercised only to cover any over-allotments of common stock.

The underwriters propose to offer the shares of common stock initially at the public offering price on the cover page of this prospectus and to selling group members at that price less a selling concession of $ per share. The underwriters and the selling group members may allow a discount of $ per share on sales to other broker/ dealers. After the initial public offering, the underwriters may change the public offering price and concession and discount to broker/ dealers.

The following table summarizes the compensation and estimated expenses we will pay:

	Per Share		**Total**	
	Without Over-allotment	**With Over-allotment**	**Without Over-allotment**	**With Over-allotment**
Underwriting Discounts and Commissions paid by us	$	$	$	$
Expenses payable by us	$	$	$	$

We estimate that our out-of-pocket expenses for this offering will be approximately million, consisting of for SEC registration fees, for New York Stock Exchange listing fees, for printing expenses, million for legal fees, million for accounting fees, for NASD filing fees and for miscellaneous expenses.

We have agreed that we will not offer, sell, contract to sell, pledge or otherwise dispose of, directly or indirectly, or file with the SEC a registration statement under the Securities Act relating to, any shares of our common stock or

securities convertible into or exchangeable or exercisable for any shares of our common stock ("lock-up" securities), or publicly disclose the intention to make any offer, sale, pledge, disposition or filing, without the prior written consent of Credit Suisse Securities (USA) LLC and UBS Securities LLC, for a period of one year after the date of this prospectus, except (1) shares issued in consideration for the acquisition of any interest in a business, (2) grants of director or employee equity awards pursuant to the terms of any plan in effect on the date of this prospectus or issuances of "lock-up" securities pursuant to the exercise of any such awards issued in the form of options and (3) securities issued in connection with any claim against us under any share acquisition agreement or by a non-medical heir, as described in "Risk Factors—Risks Relating to Our Common Stock." However, in the event that either (1) during the last 17 days of the "lock-up" period, we release earnings results or material news or a material event relating to us occurs or (2) prior to the expiration of the "lock-up" period, we announce that we will release earnings results during the 16-day period beginning on the last day of the "lock-up" period, then in either case the expiration of the "lock-up" period will be extended until the expiration of the 18-day period beginning on the date of the release of the earnings results or the occurrence of the material news or event, as applicable, unless Credit Suisse Securities (USA) LLC and UBS Securities LLC waive, in writing, such an extension.

Our directors and executive officers, the selling shareholders and certain other principal shareholders have agreed that during the "lock-up" period, they will not offer, sell, contract to sell, pledge or otherwise dispose of, directly or indirectly, any shares of our common stock or securities convertible into or exchangeable or exercisable for any shares of our common stock, enter into a transaction that would have the same effect, or enter into any swap, hedge or other arrangement that transfers, in whole or in part, any of the economic consequences of ownership of our common stock, or publicly disclose the intention to make any offer, sale, pledge or disposition, or to enter into any transaction, swap, hedge or other arrangement, without, in each case, the prior written consent of Credit Suisse Securities (USA) LLC and UBS Securities LLC, except for any transfer pursuant to gift, devise or intestate succession, provided that in the case of any gift, the donee of the transferred shares must enter into a "lock-up" agreement with Credit Suisse Securities (USA) LLC and UBS Securities LLC substantially in the same form as that set forth in the underwriting agreement. The initial "lock-up" period will commence on the date of this prospectus and will continue for five years after the date of the commencement of the public offering of the offered securities; provided, however, that beginning one year from the date of this prospectus, our board of directors may authorize the sale of up to shares of common stock by the selling shareholders and at any date thereafter on which the board of directors has determined that all claims described under "Risk Factors— " in the final prospectus has been settled, the board of directors may terminate the "lock-up" period. However, in the event that either (1) during the last 17 days of the one-year period described above or the initial "lock-up" period or the period ending on the later date referred to above, we release earnings results or material news or a material event relating to us occurs or (2) prior to the expiration of the one-year period described above or the initial "lock-up" period or the period ending on the later date referred to above, we announce that we will release earnings results during the 16-day period beginning on the last day of the one-year period described above or the initial "lock-up" period or the period ending on the later date referred to above, then in either case the expiration of the one-year period described above or the initial "lock-up" period or the period ending on the later date referred to above will be extended until the expiration of the 18-day period beginning on the date of the release of the earnings results or the occurrence of the material news or event, as applicable, unless Credit Suisse Securities (USA) LLC and UBS Securities LLC waive, in writing, such an extension.

We have been advised by Credit Suisse Securities (USA) LLC and UBS Securities LLC that they have no present intent or arrangement to release any shares of our common stock subject to a lock-up and will consider the release of any lock-up on a case-by-case basis. Upon a request to release any shares of our common stock subject to a lock-up, Credit Suisse (USA) LLC and UBS Securities LLC would consider the particular circumstances surrounding the request, including but not limited to, the length of time before the lock-up expires, the number of shares requested to be released, the reasons for the request, the possible impact on the market for our shares of common stock and whether the holder of shares requesting the release is an officer, director or other affiliate of us.

The underwriters have reserved for sale at the initial public offering price up to shares of common stock for employees, directors and other persons associated with us who have expressed an interest in purchasing shares of our common stock in the offering. The number of shares available for sale to the general public in the offering will be reduced to the extent these persons purchase the reserved shares. Any reserved shares not so purchased will be offered by the underwriters to the general public on the same terms as the other shares.

We and the selling shareholders have agreed to indemnify the underwriters against liabilities under the Securities Act or contribute to payments that the underwriters may be required to make in that respect.

We intend to apply to list our common stock on the New York Stock Exchange under the symbol "GTS."

Prior to the offering, there has been no public market for our common stock. The initial public offering price will be determined by negotiation between us and the representatives and will not necessarily reflect the market price of the common stock following the offering. The principal factors that will be considered in determining the initial public offering price will include:

- the information presented in this prospectus and otherwise available to the underwriters;
- the history of and prospects for our industry in which we will compete;
- an assessment of our management;
- our present operations;
- our historical results of operations;
- our earnings prospects;
- the general condition of the securities markets at the time of the offering; and
- the recent market prices of, and the demand for, publicly-traded common stock of generally comparable companies.

We cannot assure you that the initial public offering price will correspond to the price at which the common stock will trade in the public market subsequent to this offering or that an active trading market for the common stock will develop and continue after this offering.

Certain of the underwriters and their respective affiliates have in the past and may in the future perform various financial advisory, investment banking and other services for us, our affiliates and our officers in the ordinary course of business, for which they received and will receive customary fees and expenses. As broker-dealers who make a market in debt securities, the underwriters and their respective affiliates, in the ordinary course of their trading and brokerage activities, from time to time may own some of our outstanding debt securities or otherwise trade or effect transactions for their own accounts or the accounts of customers.

In connection with the offering, the underwriters may engage in stabilizing transactions, over-allotment transactions, syndicate covering transactions and penalty bids in accordance with Regulation M under the Exchange Act.

- Over-allotment involves sales by the underwriters of shares in excess of the number of shares the underwriters are obligated to purchase, which creates a syndicate short position for the underwriters. The short position may be either a covered short position or a naked short position. In a covered short position, the number of shares over-allotted by the underwriters is not greater than the number of shares that they may purchase in the over-allotment option. In a naked short position, the number of shares involved is greater than the number of shares in the over-allotment option. The underwriters may close out any covered short position by either exercising their over-allotment option and/or purchasing shares in the open market.

- Stabilizing transactions permit bids to purchase the underlying security so long as the stabilizing bids do not exceed a specified maximum.

- Syndicate covering transactions involve purchases of the common stock in the open market after the distribution has been completed in order to cover syndicate short positions. In determining the source of shares to close out the short position, the underwriters will consider, among other things, the price of shares available for purchase in the open market as compared to the price at which they may purchase shares through the over-allotment option. If the underwriters sell more shares than could be covered by the over- allotment option, a naked short position, the position can only be closed out by buying shares in the open market. A naked short position is more likely to be created if the underwriters are concerned that there could be downward pressure on the price of the shares in the open market after pricing that could adversely affect investors who purchase in the offering.

- Penalty bids permit the underwriters to reclaim a selling concession from a syndicate member when the common stock originally sold by such syndicate member are purchased in a stabilizing or syndicate covering transaction to cover syndicate short positions.

These stabilizing transactions, syndicate covering transactions and penalty bids may have the effect of raising or maintaining the market price of our common stock or preventing or retarding a decline in the market price of the common stock. As a result the price of our common stock may be higher than the price that might otherwise exist in the open market. These transactions may be effected on the NYSE or otherwise and, if commenced, may be discontinued at any time.

A prospectus in electronic format may be made available on the web sites maintained by one or more of the underwriters, or selling group members, if any, participating in this offering and one or more of the underwriters participating in this offering may distribute prospectuses electronically. The representatives may agree to allocate a number of shares to underwriters and selling group members for sale to their online brokerage account holders. Internet distributions will be allocated by the underwriters and selling group members that will make internet distributions on the same basis as other allocations.

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SELLING RESTRICTIONS

Our shares of common stock are being offered for sale in those jurisdictions where it is lawful to make such offers.

United Kingdom

Our shares of common stock may not be offered or sold and will not be offered or sold to any persons in the United Kingdom other than persons whose ordinary activities involve them in acquiring, holding, managing or disposing of investments (as principal or as agent) for the purposes of their businesses and in compliance with all applicable provisions of the Financial Services and Markets Act 2000 ("FSMA") with respect to anything done in relation to our common stock in, from or otherwise involving the United Kingdom.

In addition, each underwriter:

- has only communicated or caused to be communicated and will only communicate or cause to be communicated an invitation or inducement to engage in investment activity (within the meaning of section 21 of FSMA) to persons who have professional experience in matters relating to investments falling within Article 19(5) of the Financial Services and Markets Act of 2000 (Financial Promotion) Order 2005 or in circumstances in which section 21 of FSMA does not apply to the company; and

- has complied with, and will comply with all applicable provisions of FSMA with respect to anything done by it in relation to the common stock in, from or otherwise involving the United Kingdom.

European Economic Area

In relation to each Member State of the European Economic Area which has implemented the Prospectus Directive (each, a "Relevant Member State"), with effect from and including the date on which the Prospectus Directive is implemented in that Relevant Member State (the "Relevant Implementation Date") our common stock will not be offered to the public in that Relevant Member State prior to the publication of a prospectus in relation to the common stock which has been approved by the competent authority in that Relevant Member State or, where appropriate, approved in another Relevant Member State and notified to the competent authority in that Relevant Member State, all in accordance with the Prospectus Directive, except that it may, with effect from and including the Relevant Implementation Date, make an offer of common stock to the public in that Relevant Member State at any time,

- to legal entities which are authorized or regulated to operate in the financial markets or, if not so authorized or regulated, whose corporate purpose is solely to invest in securities;

- to any legal entity which has two or more of (1) an average of at least 250 employees during the last financial year; (2) a total balance sheet of more than €43,000,000 and (3) an annual net turnover of more than €50,000,000, as shown in its last annual or consolidated accounts;

- to fewer than 100 natural or legal persons (other than qualified investors as defined in the Prospectus Directive) subject to obtaining the prior consent of the manager for any such offer; or

- in any other circumstances which do not require the publication by the Issuer of a prospectus pursuant to Article 3 of the Prospectus Directive.

For the purposes of this provision, the expression an "offer of common stock to the public" in relation to any shares in any Relevant Member State means the communication in any form and by any means of sufficient information on the

terms of the offer and the common stock to be offered so as to enable an investor to decide to purchase or subscribe the common stock, as the same may be varied in that Relevant Member State by any measure implementing the Prospectus Directive in that Relevant Member State and the expression Prospectus Directive means Directive 2003/71/ EC and includes any relevant implementing measure in each Relevant Member State.

Hong Kong

The underwriters and each of their affiliates have not (i) offered or sold, and will not offer or sell, in Hong Kong, by means of any document, our common stock other than (a) to "professional investors" as defined in the Securities and Futures Ordinance (Cap. 571) of Hong Kong and any rules made under that Ordinance or (b) in other circumstances which do not result in the document being a "prospectus" as defined in the Companies Ordinance (Cap. 32) of Hong Kong or which do not constitute an offer to the public within the meaning of that Ordinance or (ii) issued or had in its possession for the purposes of issue, and will not issue or have in its possession for the purposes of issue, whether in Hong Kong or elsewhere any advertisement, invitation or document relating to our common stock which is directed at, or the contents of which are likely to be accessed or read by, the public in Hong Kong (except if permitted to do so under the securities laws of Hong Kong) other than with respect to our securities which are or are intended to be disposed of only to persons outside Hong Kong or only to "professional investors" as defined in the Securities and Futures Ordinance and any rules made under that Ordinance. The contents of this document have not been reviewed by any regulatory authority in Hong Kong. You are advised to exercise caution in relation to the offer. If you are in any doubt about any of the contents of this document, you should obtain independent professional advice.

Singapore

This prospectus or any other offering material relating to our common stock has not been and will not be registered as a prospectus with the Monetary Authority of Singapore, and the shares of common stock will be offered in Singapore pursuant to exemptions under Section 274 and Section 275 of the Securities and Futures Act, Chapter 289 of Singapore (the "Securities and Futures Act"). Accordingly, our common stock may not be offered or sold, or be the subject of an invitation for subscription or purchase, nor may this prospectus or any other offering material relating to our common stock be circulated or distributed, whether directly or indirectly, to the public or any member of the public in Singapore other than (a) to an institutional investor or other person specified in Section 274 of the Securities and Futures Act, (b) to a sophisticated investor, and in accordance with the conditions specified in Section 275 of the Securities and Futures Act or (c) otherwise pursuant to, and in accordance with the conditions of, any other applicable provision of the Securities and Futures Act.

Japan

Our common stock will not be offered or sold directly or indirectly in Japan or to, or for the benefit of, any Japanese person or to others, for re-offering or re-sale directly or indirectly in Japan or to any Japanese person, except in each case pursuant to an exemption from the registration requirements of, and otherwise in compliance with, the Securities and Exchange Law of Japan and any other applicable laws and regulations of Japan. For purposes of this paragraph, "Japanese person" means any person resident in Japan, including any corporation or other entity organized under the laws of Japan.

Switzerland

Our common stock may be offered in Switzerland only on the basis of a non-public offering. This prospectus does not constitute an issuance prospectus according to articles 652a or 1156 or the Swiss Federal Code of Obligations or a listing prospectus according to article 32 of the Listing Rules of the Swiss exchange. Our common stock may not be offered or distributed on a professional basis in or from Switzerland and neither this prospectus nor any other offering material relating to shares of our common stock may be publicly issued in connection with any such offer or distribution. The shares have not been and will not be approved by any Swiss regulatory authority. In particular, the shares are not and will not be registered with or supervised by the Swiss Federal Banking Commission, and investors may not claim protection under the Swiss Investment Fund Act.

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NOTICE TO CANADIAN RESIDENTS

Resale Restrictions

The distribution of the common stock in Canada is being made only on a private placement basis exempt from the requirement that we and the selling shareholders prepare and file a prospectus with the securities regulatory authorities in each province where trades of common stock are made. Any resale of the common stock in Canada must be made under applicable securities laws which will vary depending on the relevant jurisdiction, and which may require resales to be made under available statutory exemptions or under a discretionary exemption granted by the applicable Canadian securities regulatory authority. Purchasers are advised to seek legal advice prior to any resale of the common stock.

Representations of Purchasers

By purchasing common stock in Canada and accepting a purchase confirmation a purchaser is representing to us, the selling shareholders and the dealer from whom the purchase confirmation is received that:

- the purchaser is entitled under applicable provincial securities laws to purchase the common stock without the benefit of a prospectus qualified under those securities laws;
- where required by law, that the purchaser is purchasing as principal and not as agent;
- the purchaser has reviewed the text above under Resale Restrictions; and
- the purchaser acknowledges and consents to the provision of specified information concerning its purchase of the common stock to the regulatory authority that by law is entitled to collect the information.

Further details concerning the legal authority for this information is available on request.

Rights of Action — Ontario Purchasers Only

Under Ontario securities legislation, certain purchasers who purchase a security offered by this prospectus during the period of distribution will have a statutory right of action for damages, or while still the owner of the common stock, for rescission against us and the selling shareholders in the event that this prospectus contains a misrepresentation without regard to whether the purchaser relied on the misrepresentation. The right of action for damages is exercisable not later than the earlier of 180 days from the date the purchaser first had knowledge of the facts giving rise to the cause of action and three years from the date on which payment is made for the common stock. The right of action for rescission is exercisable not later than 180 days from the date on which payment is made for the common stock. If a purchaser elects to exercise the right of action for rescission, the purchaser will have no right of action for damages against us or the selling shareholders. In no case will the amount recoverable in any action exceed the price at which the common stock was offered to the purchaser and if the purchaser is shown to have purchased the securities with knowledge of the misrepresentation, we and the selling shareholders will have no liability. In the case of an action for damages, we and the selling shareholders will not be liable for all or any portion of the damages that are proven to not represent the depreciation in value of the common stock as a result of the misrepresentation relied upon. These rights are in addition to, and without derogation from, any other rights or remedies available at law to an Ontario purchaser. The foregoing is a summary of the rights available to an Ontario purchaser. Ontario purchasers should refer to the complete text of the relevant statutory provisions.

Enforcement of Legal Rights

All of our directors and officers as well as the experts named herein and the selling shareholders may be located outside of Canada and, as a result, it may not be possible for Canadian purchasers to effect service of process within Canada upon us or those persons. All or a substantial portion of our assets and the assets of those persons may be located outside of Canada and, as a result, it may not be possible to satisfy a judgment against us or those persons in Canada or to enforce a judgment obtained in Canadian courts against us or those persons outside of Canada.

LEGAL MATTERS

Certain legal matters in connection with this offering will be passed upon for us by Davis Polk & Wardwell, New York, New York. Fiddler, González & Rodríguez LLP will pass upon the validity of the shares of common stock sold in this offering and certain other matters under Puerto Rico law. Pietrantoni Méndez & Alvarez LLP will pass upon certain other legal matters for us under Puerto Rico law. The underwriters have been represented by Cravath, Swaine & Moore LLP, New York, New York.

EXPERTS

Our consolidated financial statements and schedules as of December 31, 2006 and 2005, and for each of the years in the three-year period ended December 31, 2006, have been included herein and in the registration statement in reliance upon the report of KPMG LLP, independent registered public accounting firm, appearing elsewhere herein, and upon the authority of said firm as experts in accounting and auditing. The report on the consolidated financial statements refers to the December 31, 2006 adoption of the recognition and disclosure provisions of Statement of Financial Standards No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*.

WHERE YOU CAN FIND MORE INFORMATION

We have filed with the Securities and Exchange Commission a registration statement on Form S-1 with respect to the common stock offered hereby. This prospectus, which constitutes a part of the registration statement, does not contain all of the information set forth in the registration statement or the exhibits and schedules which are part of the registration statement. For further information with respect to Triple-S Management Corporation and our common stock, reference is made to the registration statement and exhibits and schedules thereto. You may read and copy any document we file at the SEC's public reference room in Washington, D.C. Please call the Commission at 1-800-SEC-0330 for further information on the public reference room. Our SEC filings are also available to the public from the SEC's website at http://www.sec.gov.

In addition, we are subject to the information and periodic reporting requirements of the Securities Exchange Act of 1934 and file periodic reports, proxy statements and other information with the SEC. Such periodic reports, proxy statements and other information are available for inspection and copying at the SEC's public reference rooms and the website of the Commission referred to above. Information on our website does not constitute a part of this prospectus.

We intend to furnish our shareholders annual reports containing audited consolidated financial statements and will make available copies of quarterly reports for the first three quarters of each year containing unaudited interim consolidated financial information.

INDEX TO FINANCIAL STATEMENTS

TRIPLE S MANAGEMENT CORPORATION AND SUBSIDIARIES
CONSOLIDATED FINANCIAL STATEMENTS
DECEMBER 31, 2006, 2005, AND 2004
(WITH INDEPENDENT AUDITORS' REPORT THEREON)

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
Triple S Management Corporation:

We have audited the accompanying consolidated balance sheets of Triple-S Management Corporation and Subsidiaries (the Company) as of December 31, 2006 and 2005, and the related consolidated statements of earnings, stockholders' equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2006. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Triple-S Management Corporation and Subsidiaries at December 31, 2006 and 2005, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2006, in conformity with U.S. generally accepted accounting principles.

As discussed in note 18 to the consolidated financial statements, the Company adopted the recognition and disclosure provisions of Statement of Financial Accounting Standards No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, as of December 31, 2006.

March 7, 2007

Stamp No. 2155976 of the Puerto Rico
Society of Certified Public Accountants
was affixed to the record copy of this report.

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Balance Sheets
December 31, 2006 and 2005
(Dollar amounts in thousands, except per share data)

Assets	2006	2005
Investments and cash:		
Equity securities held for trading, at fair value (cost of $66,930 in 2006 and $69,397 in 2005)	$ 83,447	$ $78,215
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $714,113 in 2006 and $524,287 in 2005)	702,566	515,174
Equity securities (cost of $50,132 in 2006 and $38,675 in 2005)	61,686	51,810
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $21,004 in 2006 and $20,760 in 2005)	21,450	21,129
Policy Loans	5,194	—
Cash and cash equivalents	81,320	48,978
Total investments and cash	955,663	715,306
Premium and other receivables, net	165,358	244,038
Deferred policy acquisition costs and value of business acquired	111,417	81,568
Property and equipment, net	41,615	34,709
Net deferred tax asset	9,292	2,151
Other assets	62,164	59,690
Total assets	$ 1,345,509	$ 1,137,462
Liabilities and Stockholders' Equity		
Claim liabilities:		
Claims processed and incomplete	$ 147,211	$ 139,694
Unreported losses	150,735	143,224
Unpaid loss-adjustment expenses	16,736	14,645
Total claim liabilities	314,682	297,563
Liability for future policy benefits	180,420	—
Liability for future policy benefits related to funds withheld reinsurance	—	118,635
Unearned premiums	113,582	95,703
Policyholder deposits	45,425	41,738
Liability to Federal Employees' Health Benefits Program	13,563	4,356
Accounts payable and accrued liabilities	110,609	106,468
Borrowings	183,087	152,330
Income tax payable	9,242	—
Liability for pension benefits	32,300	11,966
Total liabilities	1,002,910	828,759
Stockholders equity:		
Common stock, $40 par value. Authorized 12,500 shares; issued and outstanding 8,911 and 8,904 at December 31 2006 and 2005, respectively	356	356
Additional paid-in capital	150,408	150,408
Retained earnings	211,266	162,964
Accumulated other comprehensive loss, net	(19,431)	(5,025)
	342,599	308,703
Commitments and contingencies		

Total liabilities and stockholders equity	$	1,345,509	$	1,137,462

See accompanying notes to consolidated financial statements.

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Earnings
Years ended December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

	2006	2005	2004
Revenues:			
Premiums earned, net	$ 1,511,626	$1,380,204	$ 1,298,959
Administrative service fees	14,089	14,445	9,242
Net investment income	42,657	29,138	26,820
Total operating revenues	1,568,372	1,423,787	1,335,021
Net realized investment gains	837	7,161	10,968
Net unrealized investment gain (loss) on trading securities	7,699	(4,709)	3,042
Other income, net	2,323	3,732	3,360
Total revenues	1,579,231	1,429,971	1,352,391
Benefits and expenses:			
Claims incurred	1,258,981	1,208,367	1,115,793
Operating expenses	236,065	181,703	171,879
Total operating costs	1,495,046	1,390,070	1,287,672
Interest expense	16,626	7,595	4,581
Total benefits and expenses	1,511,672	1,397,665	1,292,253
Income before taxes	67,559	32,306	60,138
Income tax expense (benefit):			
Current	15,407	4,033	14,606
Deferred	(2,381)	(160)	(271)
Total income taxes	13,026	3,873	14,335
Net income	$ 54,533	$ 28,433	$ 45,803
Basic net income per share	$ 6,120	$ 3,193	$ 5,135

See accompanying notes to consolidated financial statements.
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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Stockholders' Equity
and Comprehensive Income
Years ended December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

	Common stock	Additional paid-in capital	Retained earnings	Accumulated other comprehensive income (loss)	Total stockholders' equity
Balance, December 31, 2003	$ 361	$ 150,407	$ 88,728	$ 14,759	$ 254,255
Stock redemption	(5)	1	—	—	(4)
Comprehensive income:					
Net income	—	—	45,803	—	45,803
Net unrealized change in investment securities	—	—	—	1,101	1,101
Net change in minimum pension liability	—	—	—	(3)	(3)
Net change in fair value of cash-flow hedges	—	—	—	281	281
Total comprehensive income					47,182
Balance, December 31, 2004	356	150,408	134,531	16,138	301,433
Comprehensive income:					
Net income	—	—	28,433	—	28,433
Net unrealized change in investment securities	—	—	—	(18,832)	(18,832)
Net change in minimum pension liability	—	—	—	(2,788)	(2,788)
Net change in fair value of cash-flow hedges	—	—	—	457	457
Total comprehensive income					7,270
Balance, December 31, 2005	356	150,408	162,964	(5,025)	308,703
Dividends declared	—	—	(6,231)	—	(6,231)
Adjustment to initially apply SFAS No. 158, net of tax	—	—	—	(16,081)	(16,081)
Comprehensive income:					
Net income	—	—	54,533	—	54,533
Net unrealized change in investment securities	—	—	—	(3,212)	(3,212)
Net change in minimum pension liability	—	—	—	4,952	4,952
Net change in fair value of cash-flow hedges	—	—	—	(65)	(65)
Total comprehensive income					56,208
Balance, December 31, 2006	$ 356	$ 150,408	$ 211,266	$ (19,431)	$ $342,599

See accompanying notes to consolidated financial statements.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Cash Flows
Years ended December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

	2006	2005	2004
Cash flows from operating activities:			
Net income	$ 54,533	$ 28,433	$ 45,803
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	6,443	5,230	5,343
Net amortization (accretions) of investments	519	(209)	571
Provision for doubtful receivables	5,125	1,067	2,158
Deferred tax benefit	(2,381)	(160)	(271)
Net gain on sale of securities	(837)	(7,161)	(10,968)
Net unrealized (gain) loss of trading securities	(7,699)	4,709	(3,042)
Proceeds from trading securities sold or matured:			
Fixed maturities sold	—	102,667	50,330
Equity securities	27,919	36,156	26,523
Acquisition of securities in trading portfolio:			
Fixed maturities	—	(30,502)	(54,550)
Equity securities	(22,409)	(25,785)	(38,700)
Gain on sale of property and equipment	22	(1)	(16)
(Increase) decrease in assets:			
Premiums receivable	(27,951)	(8,805)	(5,054)
Agent balances	395	(3,183)	(5,902)
Accrued interest receivable	614	6	18
Other receivables	(4,521)	5,099	(2,623)
Funds withheld reinsurance receivable	118,635	(118,635)	—
Reinsurance recoverable on paid losses	(6,147)	(3,419)	(8,429)
Deferred policy acquisition costs and value of business acquired	(7,026)	(62,856)	(2,041)
Other assets	(5,934)	(16,110)	(5,138)
Increase (decrease) in liabilities:			
Claims processed and incomplete	2,803	2,412	16,267
Unreported losses	3,342	15,900	14,875
Loss-adjustment expenses	1,791	(74)	263
Liability for future policy benefits	14,022	—	—
Liability for future policy benefits related to funds withheld reinsurance	(118,635)	118,635	—
Unearned premiums	15,579	11,120	5,879
Policyholder deposits	1,810	1,231	1,003
Liability to FEHBP	9,207	(5,435)	2,320
Accounts payable and accrued liabilities	1,903	588	4,616
Income tax payable	12,595	(1,827)	(30,395)
Net cash provided by operating activities	$ 73,717	$ 49,091	$ 8,840

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Cash Flows
Years ended December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

	2006	2005	2004
Cash flows from investing activities:			
Proceeds from investments sold or matured:			
Securities available for sale:			
Fixed maturities sold	$ 51,519	$ 13,099	$ 86,112
Fixed maturities matured	32,826	22,822	69,258
Equity securities	1,209	3,488	8,436
Securities held to maturity:			
Fixed maturities matured	492	1,816	1,322
Acquisition of investments:			
Securities available for sale:			
Fixed maturities	(81,496)	(118,758)	(194,016)
Equity securities	(11,620)	(6,876)	(2,435)
Securities held to maturity:			
Fixed maturities	(500)	(8,495)	(10,154)
Acquisition of business, net of $10,403 of cash acquired	(27,793)	—	—
Net disbursements for policy loans	(415)	—	—
Capital expenditures	(11,873)	(7,574)	(3,494)
Proceeds from sale of property and equipment	2	—	15
Net cash used in investing activities	(47,649)	(100,478)	(44,956)
Cash flows from financing activities:			
Change in outstanding checks in excess of bank balances	(8,224)	3,914	6,730
Repayments of short-term borrowings	(119,547)	(174,035)	(57,355)
Proceeds from short-term borrowings	117,807	174,075	20,355
Repayments of long-term borrowings	(2,503)	(5,140)	(2,645)
Proceeds from long-term borrowings	35,000	60,000	50,000
Redemption of common stock	—	—	(4)
Dividends	(6,231)	—	—
Proceeds from annuity contracts	6,008	11,510	11,002
Surrenders of annuity contracts	(16,036)	(5,074)	(4,595)
Net cash provided by financing activities	6,274	65,250	23,488
Net increase (decrease) in cash and cash equivalents	32,342	13,863	(12,628)
Cash and cash equivalents, beginning of year	48,978	35,115	47,743
Cash and cash equivalents, end of year	$ 81,320	$ 48,978	$ 35,115

See accompanying notes to consolidated financial statements.

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

(1) Nature of Business

Triple S Management Corporation (the Company or TSM) was incorporated under the laws of the Commonwealth of Puerto Rico on January 17, 1997 to engage, among other things, as the holding company of entities primarily involved in the insurance industry.

The Company has the following wholly owned subsidiaries that are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance): (1) Triple S, Inc. (TSI) a managed care organization that provides health benefits services to subscribers through contracts with hospitals, physicians, dentists, laboratories, and other organizations located mainly in Puerto Rico; (2) Great American Life Assurance Company of Puerto Rico (GA Life), which is engaged in the underwriting of life and accident and health insurance policies and the administration of annuity contracts; and (3) Seguros Triple S, Inc. (STS), which is engaged in the underwriting of property and casualty insurance policies. The Company and TSI are members of the Blue Cross and Blue Shield Association (BCBSA).

Effective January 31, 2006, the Company completed the acquisition of 100% of the common stock of GA Life and effective June 30, 2006, the Company merged the operations of its former life and accident and health insurance subsidiary, Seguros de Vida Triple-S, Inc. (SVTS), into GA Life. The results of operations and financial position of GA Life are included in the Company's consolidated financial statements for the period following January 31, 2006. Prior to completing the acquisition of GA Life, the operations of SVTS were the sole component of the Company's life insurance segment.

The Company also has two other wholly owned subsidiaries, Interactive Systems, Inc. (ISI) and Triple C, Inc. (TC). ISI is mainly engaged in providing data processing services to the Company and its subsidiaries. TC is mainly engaged as a third party administrator for TSI in the administration of the Commonwealth of Puerto Rico Health Care Reform's business (the Reform). Also, TC provides health care advisory services to TSI and other health insurance related services to the health insurance industry.

A substantial majority of the Company's business activity is with insurers located throughout Puerto Rico, and as such, the Company is subject to the risks associated with the Puerto Rico economy.

(2) Significant Accounting Policies

The following are the significant accounting policies followed by the Company and its subsidiaries:

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared in conformity with U.S. generally accepted accounting principles (GAAP).

The consolidated financial statements include the financial statements of the Company and its subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

(b) Cash Equivalents

Cash equivalents of $37,271 and $28,030 at December 31, 2006 and 2005, respectively, consist principally of certificates of deposit and obligations of the Commonwealth of Puerto Rico and the U.S. Treasury with an initial term of less than three months. For purposes of the consolidated statements of cash flows, the Company considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents.

(c) Investments

Investment in securities at December 31, 2006 and 2005 consists mainly of U.S. Treasury securities and obligations of U.S. government instrumentalities, obligations of the Commonwealth of Puerto Rico and its

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

instrumentalities, obligations of government sponsored entities, obligations of state and political subdivisions, mortgage backed securities, collateralized mortgage obligations, corporate debt, and equity securities. The Company classifies its debt and equity securities in one of three categories: trading, available for sale, or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Securities classified as held to maturity are those securities in which the Company has the ability and intent to hold the security until maturity. All other securities not included in trading or held to maturity are classified as available for sale.

Trading and available for sale securities are recorded at fair value. Held to maturity debt securities are recorded at amortized cost, adjusted for the amortization or accretion of premiums and discounts. Unrealized holding gains and losses on trading securities are included in operations. Unrealized holding gains and losses, net of the related tax effect, on available for sale securities are excluded from operations and are reported as a separate component of other comprehensive income until realized. Transfers of securities between categories are recorded at fair value at the date of transfer. Unrealized holding gains and losses are recognized in operations for transfers into trading securities. Unrealized holding gains or losses associated with transfers of securities from held to maturity to available for sale are recorded as a separate component of other comprehensive income. The unrealized holding gains or losses included in the separate component of other comprehensive income for securities transferred from available for sale to held to maturity, are maintained and amortized into operations over the remaining life of the security as an adjustment to yield in a manner consistent with the amortization or accretion of premium or discount on the associated security.

A decline in the fair value of any available for sale or held to maturity security below cost, that is deemed to be other than temporary, results in a reduction in carrying amount to fair value. The impairment is charged to earnings and a new cost basis for the security is established. To determine whether an impairment is other than temporary, the Company considers whether it has the ability and intent to hold the investment until a market price recovery and considers whether evidence indicating the cost of the investment is recoverable outweighs evidence to the contrary. Evidence considered in this assessment includes the reasons for the impairment, the severity and duration of the impairment, market conditions, changes in value subsequent to period end and forecasted performance of the investee.

Premiums and discounts are amortized or accreted over the life of the related held to maturity or available for sale security as an adjustment to yield using the effective interest method. Dividend and interest income are recognized when earned.

The Company regularly invests in mortgaged-backed securities and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount for mortgaged-backed securities is based on historical experience and estimates of future payment speeds on the underlying mortgage loans. Actual prepayment speeds will differ from original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Realized gains and losses from the sale of available for sale securities are included in operations and are determined on a specific identification basis.

(d) Revenue Recognition

(i) Managed Care

Subscriber premiums on the managed care business are billed in advance of their respective coverage period and the related revenue is recorded as earned during the coverage period. Managed care premiums are billed in the month prior to the effective date of the policy with a grace period of up to two months. If the insured fails to pay, the policy can be canceled at the end of the grace period at the option of the Company. Managed care premiums are reported as earned when due.

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
December 31, 2006, 2005 and 2004
(Dollar amounts in thousands, except per share data)

Premiums for the Medicare Advantage (MA) business are based on a bid contract with the Centers for Medicare and Medicaid Services (CMS) and billed in advance of the coverage period. MA contracts provide for a risk factor to adjust premiums paid for members that represent a higher or lower risk to the Company. Retroactive rate adjustments are made periodically based on the aggregate health status and risk scores of the Company's MA membership. These risk adjustments are periodically recorded based on actuarial estimates.

The Company offers prescription drug coverage to Medicare eligible beneficiaries as part of its MA plans (MA-PD) and on a stand-alone basis (stand-alone PDP). Premiums are based on a bid contract with CMS that considers the estimated costs of providing prescription drug benefits to enrolled participants. MA-PD and stand-alone PDP premiums are subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug costs included in the bids to CMS to actual prescription drug costs. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or in the Company refunding CMS a portion of the premiums collected. The Company estimates and records adjustments to earned premiums related to estimated risk corridor payments based upon actual prescription drug costs for each reporting period as if the annual contract were to end at the end of each reporting period.

Administrative service fees include revenue from certain groups which have managed care contracts that provide for the group to be at risk for all or a portion of their claims experience. For these groups, the Company is not at risk and only handles the administration of the insurance coverage for an administrative service fee. The Company pays claims under self funded arrangements from its own funds, and subsequently receives reimbursement from these groups. Claims paid under self-funded arrangements are excluded from the claims incurred in the accompanying consolidated financial statements. Administrative service fees under the self funded arrangements are recognized based on the group's membership or incurred claims for the period multiplied by an administrative fee rate plus other fees. In addition, some of these self funded groups purchase aggregate and/or specific stop loss coverage. In exchange for a premium, the group's aggregate liability or the group's liability on any one episode of care is capped for the year. Premiums for the stop loss coverage are actuarially determined based on experience and other factors and are recorded as earned over the period of the contract in proportion to the coverage provided. This fully insured portion of premiums is included within the premiums earned, net in the accompanying consolidated statements of earnings. In addition, accounts for certain self insured groups are charged or credited with interest expense or income as provided by the group's contracts.

(ii) Life and Accident and Health Insurance

Premiums on life insurance policies are billed in advance of their respective coverage period and the related revenue is recorded as earned when due. Premiums on accident and health and other short-term policies are recognized as earned primarily on a pro rata basis over the contract period. Premiums on credit life policies are recognized as earned in proportion to the amounts of insurance in-force. Revenues from universal life and interest sensitive policies represent amounts assessed against policyholders, including mortality charges, surrender charges actually paid, and earned policy service fees. The revenues for limited payment contracts are recognized over the period that benefits are provided rather than on collection of premiums.

(iii) Property and Casualty Insurance

Premiums on property and casualty contracts are recognized as earned on a pro rata basis over the policy term. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheets as

unearned premiums and is transferred to premium revenue as earned.

(e) Allowance for Doubtful Receivables

The allowance for doubtful receivables is based on management's evaluation of the aging of accounts and such other factors, which deserve current recognition. Actual results could differ from these estimates. Receivables are charged against their respective allowance accounts when deemed to be uncollectible.

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(f) Deferred Policy Acquisition Costs and Value of Business Acquired

Certain costs for acquiring life and accident and health, and property and casualty insurance business are deferred by the Company. Acquisition costs related to the managed care business are expensed as incurred.

In the life and accident and health business deferred acquisition costs consist of commissions and certain expenses related to the production of life, annuity, accident and health, and credit business. The amount of deferred policy acquisition costs is reduced by a provision for future maintenance and settlement expenses which are not provided through future premiums. The related amortization is provided, considering interest, over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to expected total premium revenue to be received over the life of the policies. Expected premium revenue is estimated by using the same mortality and withdrawal assumptions used in computing liabilities for future policy benefits. The method followed in computing deferred policy acquisition costs limits the amount of such deferred costs to their estimated net realizable value. In determining estimated net realizable value, the computations give effect to the premiums to be earned, related investment income, losses and loss-adjustment expenses, and certain other costs expected to be incurred as the premium is earned. Costs deferred on universal life and interest sensitive products are amortized as a level percentage of the present value of anticipated gross profits from investment yields, mortality and surrender charges. Estimates used are based on the Company's experience as adjusted to provide for possible adverse deviations. These estimates are periodically reviewed and compared with actual experience. When it is determined that future expected experience differs significantly from that assumed, the estimates are revised for current and future issues.

The value assigned to the insurance in-force of GA Life at the date of the acquisition is amortized using methods similar to those used to amortize the deferred policy acquisition costs of the life and accident and health business.

In the property and casualty business, acquisition costs consist of commissions incurred during the production of business and are deferred and amortized ratably over the terms of the policies.

(g) Property and Equipment

Property and equipment are stated at cost. Maintenance and repairs are expensed as incurred. Depreciation is calculated on the straight line method over the estimated useful lives of the assets. Costs of computer equipment, programs, systems, installations, and enhancements are capitalized and amortized straight line over their estimated useful lives. The following is a summary of the estimated useful lives of the Company's property and equipment:

Asset category	Estimated useful life
Buildings	20 to 50 years
Building improvements	3 to 5 years
Leasehold improvements	Shorter of estimated useful life or lease term
Office furniture	5 years
Computer equipment, equipment, and automobiles	3 years

(h) Claim Liabilities

Claims processed and incomplete and unreported losses for managed care policies represent the estimated amounts to be paid to providers based on experience and accumulated statistical data. Loss adjustment expenses related to such claims are accrued currently based on estimated future expenses necessary to process such claims.

TSI contracts with various independent practice associations (IPAs) for certain medical care services provided to some policies subscribers. The IPAs are compensated on a capitation basis. In the Reform business and one of the MA policies, TSI retains a portion of the capitation payments to provide for incurred but not reported losses. At

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December 31, 2006 and 2005, total withholdings and capitation payable amounted to $23,796 and $27,327, respectively, which are recorded as part of the liability for claims processed and incomplete in the accompanying consolidated balance sheets.

Unpaid claims and loss adjustment expenses of the life and accident and health business are based on a case-basis estimates for reported claims, and on estimates, based on experience, for unreported claims and loss adjustment expenses. The liability for policy and contract claims and claims expenses has been established to cover the estimated net cost of insured claims.

The liability for losses and loss adjustment expenses for the property and casualty business represents individual case estimates for reported claims and estimates for unreported losses, net of any salvage and subrogation based on past experience modified for current trends and estimates of expenses for investigating and settling claims.

The above liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed, and any adjustments are reflected in the consolidated statements of earnings in the period determined.

(i) Future Policy Benefits

The liability for future policy benefits has been computed using the level-premium method based on estimated future investment yield, mortality, and withdrawal experience. The interest rate assumption is 5.0% for all years in issue. Mortality has been calculated principally on select and ultimate tables in common usage in the industry. Withdrawals have been determined principally based on industry tables, modified by Company's experience.

(j) Policyholder Deposits

Amounts received for annuity contracts are considered deposits and recorded as a liability. Interest accrued on such deposits, which amounted to $1,810, $1,230, and $1,004, during the years ended December 31, 2006, 2005, and 2004, respectively, is recorded as interest expense in the accompanying consolidated statements of earnings.

(k) Reinsurance

In the normal course of business, the insurance related subsidiaries seek to limit their exposure that may arise from catastrophes or other events that cause unfavorable underwriting results by reinsuring certain levels of risk in various areas of exposure with other insurance enterprises or reinsurers.

Reinsurance premiums, commissions, and expense reimbursements, related to reinsured business are accounted for on bases consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Accordingly, reinsurance premiums are reported as prepaid reinsurance premiums and amortized over the remaining contract period in proportion to the amount of insurance protection provided.

Premiums ceded and recoveries of losses and loss adjustment expenses have been reported as a reduction of premiums earned and losses and loss adjustment expenses incurred, respectively. Commission and expense allowances received

by STS in connection with reinsurance ceded have been accounted for as a reduction of the related policy acquisition costs and are deferred and amortized accordingly. Amounts recoverable from reinsurers are estimated in a manner consistent with the claim liability associated with the reinsured policy.

(l) Derivative Instruments and Hedging Activities

The Company accounts for derivative instruments, including certain derivative instruments embedded in other contracts, and hedging activities in accordance with the provisions of Statement of Financial Accounting Standards (SFAS) No. 133, *Accounting for Derivative Instruments and Certain Hedging Activities*, and SFAS No. 138, *Accounting for Certain Derivative Instruments and Certain Hedging Activities, an Amendment to SFAS No. 133*.

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These statements require that all derivative instruments, whether or not designated in hedging relationships, be recorded on the balance sheets at their respective fair values. Changes in the fair value of derivative instruments are recorded in earnings, unless specific hedge accounting criteria are met in which case the change in fair value of the instrument is recorded within other comprehensive income.

On the date the derivative contract designated as a hedging instrument is entered into, the Company designates the instrument as either a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment (fair value hedge), a hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability (cash flow hedge), a foreign currency fair value or cash flow hedge (foreign currency hedge), or a hedge of a net investment in a foreign operation. For all hedging relationships the Company formally documents the hedging relationship and its risk management objective and strategy for undertaking the hedge, the hedging instrument, the hedged item, the nature of the risk being hedged, how the hedging instrument's effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking all derivatives that are designated as fair value, cash flow, or foreign currency hedges to specific assets and liabilities on the balance sheet or to specific firm commitments or forecasted transactions. The Company also formally assesses, both at the hedge's inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a fair value hedge, along with the loss or gain on the hedged asset or liability or unrecognized firm commitment of the hedged item that is attributable to the hedged risk, are recorded in earnings. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash flow hedge are recorded in other comprehensive income to the extent that the derivative is effective as hedge, until earnings are affected by the variability in cash flows of the designated hedged item. Changes in the fair value of derivatives that are highly effective as hedges and that are designated and qualify as foreign currency hedges are recorded in either earnings or other comprehensive income, depending on whether the hedge transaction is a fair value hedge or a cash flow hedge. However, if a derivative is used as a hedge of a net investment in a foreign operation, its changes in fair value, to the extent effective as a hedge, are recorded in the cumulative translation adjustments account within other comprehensive income. The ineffective portion of the change in fair value of a derivative instrument that qualifies as either a fair value hedge or a cash flow hedge is reported in earnings. Changes in the fair value of derivative trading instruments are reported in current period earnings.

The Company discontinues hedge accounting prospectively when it is determined that the derivative is no longer effective in offsetting changes in the fair value or cash flows of the hedged item, the derivative expires or is sold, terminated, or exercised, the derivative is de designated as a hedging instrument, because it is unlikely that a forecasted transaction will occur, a hedged firm commitment no longer meets the definition of a firm commitment, or management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued and the derivative is retained, the Company continues to carry the derivative at its fair value on the balance sheet and recognizes any subsequent changes in its fair value in earnings. When hedge accounting is discontinued because it is determined that the derivative no longer qualifies as an effective fair value hedge, the Company no longer adjusts the hedged asset or liability for changes in fair value. The adjustment of the carrying amount of the hedged asset or liability is accounted for in the same manner as other components of the carrying amount of that asset or liability. When hedge accounting is discontinued because the hedged item no longer meets the definition of a firm commitment, the Company removes any asset or liability that was recorded pursuant to recognition of the firm commitment from the balance sheet, and recognizes any gain or loss

in earnings. When it is probable that a forecasted transaction will not occur, the Company discontinues hedge accounting if not already done and recognizes immediately in earnings gains and losses that were accumulated in other comprehensive income.

(m) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying

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amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the consolidated statements of earnings in the period that includes the enactment date.

(n) Insurance related Assessments

The Company accounts for insurance related assessments in accordance with the provisions of Statement of Position (SOP) No. 97 3, *Accounting by Insurance and Other Enterprises for Insurance related Assessments*. This SOP prescribes liability recognition when the following three conditions are met: (1) the assessment has been imposed or the information available prior to the issuance of the financial statements indicates it is probable that an assessment will be imposed; (2) the event obligating an entity to pay (underlying cause of) an imposed or probable assessment has occurred on or before the date of the financial statements; and (3) the amount of the assessment can be reasonably estimated. Also, this SOP provides for the recognition of an asset when the paid or accrued assessment is recoverable through either premium taxes or policy surcharges.

(o) Impairment of Long lived Assets

In accordance with SFAS No. 144, *Accounting for the Impairment or Disposal of Long lived Assets*, long lived assets, such as property and equipment, and purchased intangible assets subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposal group classified as held for sale would be presented separately in the appropriate asset and liability sections of the balance sheets.

Goodwill and intangible assets that have indefinite useful lives are tested annually for impairment, and are tested for impairment more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. For goodwill, the impairment determination is made at the reporting unit level and consists of two steps. First, the Company determines the fair value of a reporting unit and compares it to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation, in accordance with SFAS No. 141, *Business Combinations*. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

(p) Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, and penalties and other sources are recorded when it is probable that a liability has been incurred and the amount of the assessment and/or remediation

can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred. Recoveries of costs from third parties, which are probable of realization, are separately recorded as assets, and are not offset against the related liability.

(q) Use of Estimates

The preparation of the consolidated financial statements in conformity with U.S. GAAP requires the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the

disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates. The most significant items on the consolidated balance sheets that involve a greater degree of accounting estimates and actuarial determinations subject to changes in the future are the claim liabilities, the deferred policy acquisition costs and value of business acquired, the liability for future policy benefits, liability for pension benefits and the allowance for doubtful receivables. As additional information becomes available (or actual amounts are determinable), the recorded estimates will be revised and reflected in operating results. Although some variability is inherent in these estimates, the Company believes the amounts provided are adequate.

(r) Fair Value of Financial Instruments

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of investments in corporate bonds, premiums receivable, accrued interest receivable, and other receivables.

The fair value information of financial instruments in the accompanying consolidated financial statements was determined as follows:

(i) Cash and Cash Equivalents

The carrying amount approximates fair value because of the short term nature of such instruments.

(ii) Investment in Securities

The fair value of investment securities is estimated based on quoted market prices for those or similar investments. Additional information pertinent to the estimated fair value of investment in securities is included in note 4.

(iii) Policy Loans

Policy loans have no stated maturity dates and are part of the related insurance contract. The carrying amount of policy loans approximates fair value because their interest rate is reset periodically in accordance with current market rates.

(iv) Receivables, Accounts Payable, and Accrued Liabilities

The carrying amount of receivables, accounts payable, and accrued liabilities approximates fair value because they mature and should be collected or paid within 12 months after December 31.

(v) Policyholder Deposits

The fair value of policyholder deposits is the amount payable on demand at the reporting date, and accordingly, the carrying value amount approximates fair value.

(vi) Short term Borrowings

The carrying amount of securities sold under agreements to repurchase is a reasonable estimate of fair value due to its short term nature.

(vii) Long term Borrowings

The carrying amounts and fair value of the Company's long term borrowings are as follows:

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	2006		2005	
	Carrying amount	Fair value	Carrying amount	Fair value
Loans payable to bank	$ 38,087	$ 38,087	$ 40,590	$ 40,590
6.3% senior unsecured notes payable	50,000	47,897	50,000	49,546
6.6% senior unsecured notes payable	60,000	58,104	60,000	60,000
6.7% senior unsecured notes payable	35,000	34,062	—	—
Totals	$ 183,087	$ 178,150	$ 150,590	$ 150,136

The carrying amount of the loans payable to bank approximates fair value due to its floating interest rate structure. The fair value of the senior unsecured notes payable was determined using market quotations. Additional information pertinent to long term borrowings is included in note 11.

(viii) Derivative Instruments

Current market pricing models were used to estimate fair value of interest rate swap agreement and structured notes agreements. Fair values were determined using market quotations provided by outside securities consultants or prices provided by market makers. Additional information pertinent to the estimated fair value of derivative instruments is included in note 12.

(s) Earnings Per Share

The Company calculates and presents earnings per share in accordance with SFAS No. 128, *Earnings per Share*. Basic earnings per share exclude dilution and are computed by dividing net income available to common stockholders by the weighted average number of common shares outstanding for the period (see note 22). Because the Company has not issued convertible debt, options, warrants or contingent stock agreements, there is no potential dilution that could affect basic earnings per share.

(t) Recently Issued Accounting Standards

In September 2006, the Securities and Exchange Commission issued Staff Accounting Bulletin (SAB) No. 108, *Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements*, addressing how the effects of prior-year uncorrected financial statement misstatements should be considered in current year financial statements. SAB No. 108 requires registrants to quantify misstatements using both balance sheet and income statement approaches in evaluating whether or not a misstatement is material. SAB No. 108 is effective for fiscal years ended after November 15, 2006. The adoption of this SAB did not have a material impact on the Company's consolidated financial statements.

SFAS No. 158, *Employers' Accounting for Defined Benefit Pension and Other Postretirement Plans*, was issued in September 2006. This statement changes financial reporting by requiring employers to recognize the overfunded or underfunded status of a defined benefit postretirement plan as an asset or liability in its statement of financial position and to recognize changes in that funded status in the year in which the changes occur through comprehensive income. This statement also changes financial reporting by requiring employers to measure the funded status of a plan as of the date of its year-end statement of financial position. An employer with publicly traded equity securities is required to initially recognize the funded status of a defined benefit postretirement plan and to provide required disclosures as of

the end of the fiscal year ended after December 15, 2006. An employer without publicly traded equity securities is required to recognize the funded status of a defined benefit pension plan and to provide required disclosures as of the end of the fiscal year ending after June 15, 2007. The requirement to measure plan assets and benefit obligations as of the date of the employer's fiscal year-end statement of financial position is effective for fiscal years ending after December 15, 2008. The Company adopted the provisions of this statement in the consolidated financial statements as of December 31, 2006 as further discussed in note 18.

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SFAS No. 157, *Fair Value Measurements*, was issued in September 2006. This statement defines fair value, establishes a framework for measuring fair value and expands disclosures about fair value measurements. This statement does not require any new fair value measurements; it applies under other accounting statements that require or permit fair value measurements. This statement is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. Except for certain exceptions, the provisions of this statement are to be applied prospectively as of the beginning of the fiscal year in which it is initially applied. The Company is currently evaluating the effect of this statement on its consolidated financial statements.

Financial Accounting Standards Board (FASB) Interpretation No. 48, *Accounting for Uncertainty in Income Taxes an Interpretation of FASB Statement No. 109*, was issued in June 2006. This Interpretation clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statements in accordance with SFAS No. 109, *Accounting for Income Taxes*. This interpretation prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. This Interpretation is effective for fiscal years beginning after December 15, 2006. The adoption of this Interpretation is not expected to have a material impact on the Company's consolidated financial statements.

SFAS No. 156, *Accounting for Servicing of Financial Assets, an amendment of SFAS No. 140*, was issued in March 2006. This statement amends SFAS No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, with respect to the accounting for separately recognized servicing assets and servicing liabilities. This Statement is effective as of the beginning of the first fiscal year that begins after September 15, 2006. The adoption of SFAS No. 156 is not expected to have an impact on the Company's consolidated financial statements.

SFAS No. 155, *Accounting for Certain Hybrid Financial Instruments, an amendment of FASB Statements No. 133 and 140*, was issued in February 2006. This statement amends SFAS No. 133, *Accounting for Derivatives and Hedging Activities*, and SFAS No. 140, *Accounting for Transfers and Servicing of Financial Assets and Extinguishments of Liabilities*, and allows an entity to remeasure at fair value a hyb