TRIPLE-S MANAGEMENT CORP
Form S-1/A
November 16, 2007

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As filed with the Securities and Exchange Commission on November 16, 2007

Registration No. 333-142402

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

AMENDMENT NO. 1 TO
FORM S-1

REGISTRATION STATEMENT
UNDER
THE SECURITIES ACT OF 1933

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)

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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

CALCULATION OF REGISTRATION FEE

Title Of Each Class Of Securities To Be Registered	Proposed Maximum Aggregate Offering Price(1)(2)(3)	Amount Of Registration Fee(4)
Class B Common Stock, par value $1.00 per share	$289,800,000	$8,896.86

(1) Includes shares of common stock that may be purchased by the underwriters to cover over-allotments, if any.

(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.

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

(4) $7,675.00 was previously paid with the initial filing of the registration statement on April 27, 2007.

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 jurisdiction where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED NOVEMBER 16, 2007

14,000,000 Shares

Class B Common Stock

Prior to this offering, there has been no public market for our common stock. The initial public offering price of our Class B common stock is expected to be between $16.00 and $18.00 per share. We have applied to list our Class B common stock on the New York Stock Exchange under the symbol "GTS".

We are selling 5,000,000 shares and the selling shareholders are selling 9,000,000 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, 16,100,000 of our shares of Class B common stock, representing approximately 50.0% of our share capital, will be held by the public and 16,072,759 shares of Class A common stock, representing approximately 50.0% 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. The two classes of common stock differ due to the conversion rights of the Class A common stock and the anti-dilution rights of the Class B common stock. See "Description of Capital Stock" on page 141.

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 greater ownership interest in our company. These ownership restrictions will apply to the shares sold in this offering. See "Description of Capital Stock" on page 141 for a more detailed discussion of these restrictions.

The underwriters have an option to purchase up to 316,759 and 1,783,241 additional shares of Class B common stock 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 10.

	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**

CIBC World Markets **Citi**

Popular Securities **Santander Securities**

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 share and per share amounts in this prospectus have been restated to reflect the 3,000-for-one stock split of our common stock 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 sectors, 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) (now Triple-S Vida, Inc.) 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. In the nine months ended September 30, 2007, we generated total revenue of approximately $1.2 billion, of which approximately 87% was derived from our managed care businesses and 13% 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 we enjoy a strong competitive advantage as a result of our participation in the Blue Cross Blue Shield Association's BlueCard® PPO (BlueCard) program, which provides our members with coverage for medical attention throughout the United States, the primary travel destination of Puerto Rico residents.

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. 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 sectors, 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 we 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 provider 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 managed care provider 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 it provides us with 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 42% 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. 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 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 (a managed care program available to Medicare beneficiaries) market. We entered the Medicare Advantage market in 2005 and as of September 30, 2007 had approximately 11.3% 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 United States, 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). As of December 31, 2006, approximately 35% of Medicare beneficiaries in Puerto Rico were 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 the 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 Expansion 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.

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 and commenced operations 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.triplesmanagement.com*. The information contained therein is not incorporated by reference in this prospectus.

THE OFFERING

Common stock offered by	
Us	5,000,000 shares of Class B common stock
Selling shareholders	9,000,000 shares of Class B common stock
Total	14,000,000 shares of Class B common stock
Over-allotment option	
Us	316,759 shares of Class B common stock
Selling shareholders	1,783,241 shares of Class B common stock
Total	2,100,000 shares of Class B common stock
Common stock to be outstanding after this offering	31,856,000 shares (32,172,759 shares if the over-allotment option is exercised in full), consisting of 17,856,000 shares of Class A common stock and 14,000,000 shares of Class B common stock (16,072,759 shares of Class A common stock and 16,100,000 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 $75.6 million, assuming the shares of Class B common stock are offered at $17.00 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 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".
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.
Dividend Policy	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. See "Dividend Policy".
Conversion Rights of Class A Common Stock	At any time after the first anniversary of the completion of this offering, our board of directors may, in its sole discretion and after considering relevant factors, including market conditions at the time, cause shares of our Class A common stock to be converted to shares of Class B common stock, including in connection with one or more underwritten public offerings; provided, that the aggregate number of shares of Class A common stock that may be converted, together with

	all shares of Class A common stock that shall have been converted on any prior occasion, shall be limited to two-thirds of the number of shares of common stock outstanding immediately prior to the consummation of this offering. In addition, at any time after the fifth anniversary of the completion of this offering, or such earlier date after the first anniversary of the completion of this offering as all claims with respect to which anti-dilution protections are afforded to Class B common stock have been resolved, all or any portion of our shares of Class A common stock may, at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock, at which time the anti-dilution protections described under "Description of Capital Stock Anti-Dilution Rights" will terminate. Our Class B common stock is not convertible into any other shares of our capital stock.
Anti-Dilution Protections of Class B Common Stock	For a period of five years from the completion of this offering, subject to extension or shortening under certain circumstances, each holder of our shares of Class B common stock will benefit from anti-dilution protections provided in our amended and restated articles of incorporation, pursuant to which each holder of shares of Class B common stock 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 shares of Class B common stock 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 shares of Class B common stock 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. Our Class A common stock does not have these anti-dilution protections.
Proposed New York Stock Exchange Symbol	"GTS"

Unless otherwise indicated, the information in this prospectus:

- assumes an initial public offering price of $17.00 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 effected by us on May 1, 2007;
- assumes no exercise of the underwriters' option to purchase up to 316,759 and 1,783,241 additional shares from us and the selling shareholders, respectively, to cover over-allotments.

The number of shares of our Class B common stock to be outstanding after this offering does not take into account:

- 852,353 shares of Class B common stock issuable upon the exercise of stock options outstanding as of the closing of this offering exercisable at the initial price to the public in this offering; and
- an aggregate of 4,700,000 shares of Class B common stock that will be reserved for future issuances under our stock incentive plan as of the closing of this offering.

Risk Factors

Investing in our common stock involves substantial risk. Please read "Risk Factors" beginning on page 10 for a discussion of certain factors you should consider in evaluating an investment in our common stock.

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 and for the nine-month periods ended September 30, 2007 and 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, 2005 and 2004 from our audited consolidated financial statements.

Our unaudited consolidated financial statements have been prepared on the same basis as our audited consolidated financial statements and, in our opinion, reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of this data in all material respects. The results for any interim period are not necessarily indicative of the results that may be expected for a full year or any other period.

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 additional terms ending June 30, 2008 and applicable premium rates were negotiated, resulting in an average increase in rates of 8.7%. The premiums earned, net and operating income related to the operations of the Metro-North region for the nine months ended September 30, 2006 amounted to $145.8 million and $6.9 million, respectively. The premiums earned, net and operating income related to the operations of the Metro-North region amounted to $161.6 million and $5.4 million, respectively, for the year ended December 31, 2006, and $200.9 million and $3.5 million, respectively, for the year ended December 31, 2005.

	Nine months ended September 30,		Year Ended December 31,		
(in millions, except per share data)	**2007**	**2006(1)**	**2006(1)**	**2005**	**2004**
Statement of Earnings Data					
Revenues:					
Premiums earned, net	$ 1,101.6	$ 1,158.6	$ 1,511.6	$ 1,380.2	$ 1,299.0
Administrative service fees	11.0	10.4	14.1	14.4	9.2
Net investment income	33.4	31.3	42.7	29.1	26.8
Total operating revenues	1,146.0	1,200.3	1,568.4	1,423.7	1,335.0
Net realized investment gains	6.2	1.3	0.8	7.2	11.0
Net unrealized investment gain (loss) on trading securities	(0.8)	3.7	7.7	(4.7)	3.0
Other income, net	1.8	1.2	2.3	3.7	3.4
Total revenues	1,153.2	1,206.5	1,579.2	1,429.9	1,352.4
Benefits and expenses:					
Claims incurred	915.4	974.3	1,259.0	1,208.3	1,115.8
Operating expenses	173.4	170.5	236.1	181.7	171.9
Total operating costs	1,088.8	1,144.8	1,495.1	1,390.0	1,287.7
Interest expense	11.9	12.4	16.6	7.6	4.6
Total benefits and expenses	1,100.7	1,157.2	1,511.7	1,397.6	1,292.3
Income before taxes	52.5	49.3	67.5	32.3	60.1
Income tax expense	11.7	10.5	13.0	3.9	14.3

	Nine months ended September 30,		Year Ended December 31,		
Net income	$ 40.8	$ 38.8	$ 54.5	$ 28.4	$ 45.8

(in millions, except per share data)	Nine months ended September 30, 2007	Nine months ended September 30, 2006(1)	Year Ended December 31, 2006(1)	Year Ended December 31, 2005	Year Ended December 31, 2004
Weighted average number of shares outstanding giving effect to 3,000-for-one stock split	26,741,333	26,728,333	26,733,000	26,712,000	26,757,000
Basic net income per share giving effect to 3,000-for-one stock split	$ 1.53	$ 1.45	$ 2.04	$ 1.06	$ 1.71

(in millions)	As of September 30, 2007	As of December 31, 2006(1)	As of December 31, 2005	As of December 31, 2004
Balance Sheet Data				
Cash and cash equivalents	$ 96.0	$ 81.6	$ 49.0	$ 35.1
Total assets	1,345.5	1,137.5	919.7	
Long-term borrowings	171.4	183.1	150.6	95.7
Total shareholders' equity	382.9	342.6	308.7	301.4

	Nine months ended September 30, 2007	Nine months ended September 30, 2006	Year Ended December 31, 2006	Year Ended December 31, 2005	Year Ended December 31, 2004
Additional Managed Care Data(2)					
Medical loss ratio	87.7%	88.2%	87.6%	90.3%	88.3%
Operating expense ratio	11.0%	11.0%	11.5%	10.8%	10.8%
Medical membership (period-end)	977,613	1,189,206	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 agreement, a share acquisition agreement). These share acquisition 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, TSI, 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, our shareholders did not approve attempts to increase our 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 our or TSI's shares 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. If we or TSI were 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, only one judicial claim to enforce any of these agreements has been commenced. Additionally, we have received inquiries with respect to over 600 shares under share acquisition agreements. The share numbers set forth in this paragraph reflect the number of SSS shares provided for in the share acquisition agreements. Those agreements do not include anti-dilution protections and we do not believe that the amounts of any claims under the agreements with SSS should be multiplied to reflect our 3,000-for-one stock split. We cannot provide assurances, however, that claimants will not successfully seek to increase the size of their claims by reference to the stock split.

We have been advised by our 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 in any litigation of these claims because, among other defenses, the condition precedent to SSS's obligations under the share acquisition agreements never occurred, and any obligation it may, or we may be deemed to, 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.

We believe that we should prevail in any litigation 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 shares of Class B common stock we are offering with this prospectus include anti-dilution protections designed to offset the dilutive effect of the issuance of shares of Class A common stock in respect of such claims at below market prices on the shares of Class B common stock 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, we and our predecessor entity have restricted the ownership or transferability of our shares, including by reserving to us or our predecessor a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, we and our predecessor, consistent with the requirements of our and our predecessor's bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, 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 our shares or to damages with respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 former shareholders whose non-medical heirs may claim to have inherited up to 10,500,000 shares after giving effect to the 3,000-for-one stock split. As of the date of this prospectus, one judicial claim seeking the return of or compensation for 16 shares (prior to giving effect to the 3,000-for-one stock split) had been brought by the non-medical heirs of a former shareholder whose shares were repurchased upon his death. These heirs purport to represent as a class all non-medical heirs of deceased shareholders whose shares we repurchased. In addition, we have received inquiries from non-medical heirs with respect to over 600 shares (or 1,800,000 shares after giving effect to the 3,000-for-one stock split).

We believe that we should prevail in litigation with respect to these matters; however, we cannot predict the outcome of any such 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 shares of Class B common stock we are offering with this prospectus include anti-dilution protections designed to offset the dilutive effect of the issuance of shares of Class A common stock in respect of such claims at below market prices on the Class B common stock during a period of up to five or more 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 shares of Class B common stock.

We designed the dual class structure of capital stock described in "Description of Capital Stock" to offset the potential impact on the value of our Class B common stock attributable to any issuance of shares of common stock for less than market value in respect of a successful 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 shares of Class B common stock against any potential dilution attributable to the issuance of any shares in respect of such claims at below market prices. We cannot, however, provide any assurances 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 common stock 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 common stock. The

issuance of a significant number of shares of Class B common stock, if followed by a material further issuance of shares of common stock to separate claimants, could impair the effectiveness of the anti-dilution protections of the Class B common stock. In addition, we cannot provide any assurances that the anti-dilution protections afforded our Class B common stock 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 us 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 acquire shares of our managed care subsidiary, TSI, at less than fair value, we will not be able to prevent dilution of the value of the Class B shareholders' ownership interest in us to the extent that the net value received by such claimants exceeds the value of our outstanding shares of Class A common stock. 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 shares of Class A common stock may, at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted into shares of Class B common stock even if we have not resolved all claims against us by such time.

Risks Relating to Our Business

We could be subject to possible regulatory actions in connection with alleged illegal political contributions.

Miguel Vázquez Deynes, who was president and chief executive officer of the Company from January 1990 to April 2002, prior to the time that we became an SEC registrant, stated during a radio interview in October 2007 that he had testified to a federal grand jury to having caused the Company to effect illegal political contributions totaling over $100,000 between 1996 and 2000. Mr. Vázquez Deynes has stated publicly that the payments in question were made to Puerto Rico public relations firms for the purpose of concealing the fact that they exceeded the amounts permitted by applicable Puerto Rico election laws. Mr. Vázquez Deynes' testimony was given in connection with an ongoing investigation by the U.S. Attorney's Office for the District of Puerto Rico into illegal political contributions in Puerto Rico. The Puerto Rico Legislative Assembly and the Puerto Rico Department of Justice have subsequently launched separate investigations into the matters described by Mr. Vázquez Deynes. The Company is cooperating fully with all requests made of it in connection with these investigations.

There may be, or could in the future be, other investigations by governmental authorities relating to these matters. The current and any such future investigations could result in actions against us or certain of our current or former employees. These actions could result in fines, penalties, sanctions, injunctions against future conduct, third party litigation or other actions that could have a material adverse effect on our business, financial condition, share price and reputation, including by impairing government contracts and adversely affecting our ability to obtain future contracts and participate in governmental payor programs.

Following the airing of Mr. Vázquez's allegations, the Company's board of directors hired outside counsel from Clifford Chance US, LLP, a law firm that had no prior relationship with the Company, to conduct an internal investigation into these allegations. The internal investigation is ongoing but substantially advanced. The Company believes that any misconduct was limited to the matters publicly described by Mr. Vázquez Deynes and isolated to the period when Mr. Vázquez Deynes was an officer of the Company. Although we cannot predict the outcome of the government investigations described above, management does not currently believe that they will result in actions having a material adverse effect on the Company.

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 the Reform programs) 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 expenses 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 programs, 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/or are unable 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: We participate in the government of Puerto Rico Health Reform Program 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 the nine months ended September 30, 2007 and each of the years ended December 31, 2006, 2005 and 2004, the Reform program has accounted for 22.1%, 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 the nine months ended September 30, 2006, the Metro-North region accounted for 12.6% and 12.4% of our consolidated premiums earned, net and consolidated operating income, respectively. During each of the years ended December 31, 2006, 2005 and 2004, this region accounted for 10.7%, 14.6% and 14.2% of our consolidated premiums earned, net, respectively, and 7.3%, 10.3% and 9.3% of our consolidated operating income, respectively. 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. During the nine months ended September 30, 2007 and the year ended December 31, 2006, contracts with CMS represented 16.9% and 11.3% of our consolidated premiums earned, net, respectively, and 49.5% and 45.9% of our consolidated operating income, respectively, and may in the future represent a greater percentage of our operations.

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 the nine months ended September 30, 2007 and the years ended December 31, 2006, 2005, and 2004, premiums generated under this contract represented 8.3%, 7.5%, 8.2% and 8.3% of our consolidated premiums earned, net, respectively, and 1.1%, 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 September 30, 2007, 83.5% of our managed care customers had fully insured arrangements and 16.5% had ASO arrangements, as compared to approximately 83.9% and 16.1%, respectively, as of December 31, 2006. 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 a material 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. 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. 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. The fee is currently $86.18 per licensed enrollee. If the re-establishment fee were applied to our total Blue Shield enrollees as of September 30, 2007, we would be assessed approximately $84.3 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 the nine months ended September 30, 2007, 42.9%, or $50.3 million, of the premiums written in the property and casualty insurance segment and 9.0%, or $6.6 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 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. See " Large scale natural disasters may have a material adverse effect on our business, financial condition and results of operation". 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 were awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans and entered that market in 2006 and 2007. 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. The parent companies of 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. Competitive pressures faced by us may adversely affect our business, financial condition and results of operations. 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. If a large competitor were to acquire that right in the future, that could have a material adverse impact on our business.

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. See " Our insurance subsidiaries are subject to minimum capital requirements. Our failure to meet these requirements could subject us to regulatory action". 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 a material 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 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 is with insureds located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. Preliminary reports on the performance of the Puerto Rico economy for fiscal year 2006 indicate that real gross national product increased 0.7% and the forecast for fiscal year 2007 projects a decline of 1.4%. The major factors affecting the economy are, among others, high oil prices, the slowdown of economic activity in the United States, the continuing economic uncertainty generated by the fiscal crisis affecting the government of Puerto Rico and the effects on the economy of a recently implemented sales tax.

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 $4.0 million. In addition, we recently selected Quality Care Solutions, Inc. 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 2013 at a total cost of approximately $40.0 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.

In addition to the litigation risks discussed above in " Risks Relating to our Capital Stock", 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 agreement and note purchase agreements may restrict our operations.

We are a party to a secured loan with a commercial bank for an aggregate amount of $41.0 million, for which we had an outstanding balance of $26.4 million as of September 30, 2007. Also, we have an aggregate principal amount of $145.0 million of senior unsecured notes outstanding, 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 agreement 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 agreement 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 shares of Class B common stock 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 shares of Class B common stock. 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 shares of Class B common stock 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 shares of Class B common stock. 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,

legislation to revise Medicare and the Reform; and

increased governmental concern regarding fraud and abuse.

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. At least two U.S. House of Representatives committees are currently 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.

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 Puerto Rico and federal 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 for 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, on August 1, 2007, the U.S. House of Representatives passed the Children's Health and Medicare Protection Act of 2007 (H.R. 3162), which, among other things, would amend the Social Security Act to improve the federal government's children's health insurance program and make other changes under the Medicare and Medicaid programs. H.R. 3162 includes provisions that would gradually reduce Medicare Advantage payments over a four-year period to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program by 2011. The proposed reductions in Medicare Advantage rates are the result of hearings by the health subcommittee of the House Ways and Means Committee regarding recommendations contained in MedPac's semi-annual report to Congress on Medicare payment policy dated March 1, 2007. 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 recommended a gradual reduction in Medicare Advantage rates to ensure that payment rates between Medicare Advantage plans and the traditional Medicare program are equalized. H.R. 3162 was referred to the Senate on September 4, 2007 for consideration. As of the date of this prospectus, the U.S. Senate has not addressed H.R. 3162, nor has the U.S. Senate passed any other bill that includes the MedPac recommendations for gradual reductions in Medicare Advantage payments. We cannot provide assurances if, when or to what degree Congress may enact H.R. 3162 or similar legislation, but any reduction in Medicare Advantage rates could have a material 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.

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 requirements 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 have applied 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 5,000,000 shares of Class B common stock at an assumed initial public offering price of $17.00 per share, the midpoint 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 September 30, 2007 would have been $344.1 million, or $10.83 per share of common stock. This represents an immediate increase in net tangible book value to existing shareholders of $0.80 per share of Class A

common stock and an immediate dilution to new investors of $6.17 per share of Class B common stock. 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 limits our future ability to raise capital through an offering of equity securities. After completion of this offering, there will be 14,000,000 shares of Class B common stock and 17,856,000 shares of Class A common stock issued and outstanding, or 16,100,000 shares of Class B common stock and 16,072,759 shares of Class A common stock if the underwriters exercise their over-allotment option in full. Approximately 71.3% 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 shares of Class B common stock. In addition, at any time after the first anniversary of our initial public offering, our board of directors may, at its sole discretion and after considering relevant factors, including market conditions at the time, cause approximately half of our shares of Class A common stock to be converted to shares of Class B common stock, including in connection with an underwritten public secondary offering, subject to the limitations described in "Description of Capital Stock Description of Common Stock Conversion". In addition, at any time following the fifth anniversary of this initial public offering, or such earlier date after the first anniversary of the initial public offering as all claims with respect to which anti-dilution protections are afforded to shares of Class B common stock have been resolved, all or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock. 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 Strategy", "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", "will", "shall", "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 $75.6 million, assuming the shares of Class B common stock are offered at $17.00 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 $80.6 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 $4.7 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 for general corporate purposes, including working capital and possible acquisitions and investments.

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 $2.4 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 September 30, 2007, on an actual and as adjusted basis to reflect the issuance and sale by us of 5,000,000 shares of Class B common stock in this offering at an assumed initial public offering price of $17.00 per share, which is the midpoint 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.

	September 30, 2007	
(in millions, except per share data)	**Actual**	**Adjusted for IPO(1)**
Cash and cash equivalents	$ 96.0	$ 171.6
Long-term debt, including current portion	$ 171.4	$ 171.4
Shareholders' equity:		
Preferred stock, par value $1.00 per share, 100,000,000 shares authorized, none issued and outstanding		
Common stock, par value $1.00 per share, 100,000,000 shares authorized; 26,772,000 shares issued and outstanding (actual)	26.8	31.8
Additional paid-in capital	124.0	194.6
Retained earnings	249.6	249.6
Accumulated other comprehensive loss	(17.5)	(17.5)
Total shareholders' equity	382.9	458.5
Total capitalization	$ 554.3	$ 629.9

(1) 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 $4.7 million, 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 September 30, 2007 was approximately $268.5 million, or $10.03 per share of our common stock. 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 5,000,000 shares of Class B common stock in this offering at an assumed offering price of $17.00 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 September 30, 2007 would have been $344.1 million, or $10.83 per share of common stock. This represents an immediate increase in as-adjusted net tangible book value of $0.80 per share to our existing shareholders and an immediate dilution of $6.17 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		$ 17.00
Net tangible book value per share as of September 30, 2007	$ 10.03	
Increase per share attributable to new investors	0.80	
As-adjusted net tangible book value per share after the offering		10.83
Dilution per share of Class B common stock		$ 6.17

A $1.00 increase (decrease) in the assumed initial public offering price of $17.00 per share of Class B common stock (the midpoint of the estimated price range shown on the cover page of this prospectus) would increase (decrease) our as-adjusted net tangible book value per share of common stock after this offering by $0.15, and would increase (decrease) the dilution to new investors by $0.85, assuming the number of shares of Class B common stock 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 September 30, 2007, 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
			(millions)		
Existing shareholders (Class A)	26,772,000	84.3%	$ 0.5	0.6%	$ 0.02
New investors (Class B)	5,000,000	15.7	85.0	99.4	$ 17.00
Total	31,772,000	100.0%	$ 85.5	100.0%	

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 and for the nine-month periods ended September 30, 2007 and 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. We derived the statement of earnings data for the nine-month periods ended September 30, 2007 and 2006, and the balance sheet data as of September 30, 2007, from our unaudited consolidated financial statements.

Our unaudited consolidated financial statements have been prepared on the same basis as our audited consolidated financial statements and, in our opinion, reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of this data in all material respects. The results for any interim period are not necessarily indicative of the results that may be expected for a full year or any other period.

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 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 additional terms ending June 30, 2008 and applicable premium rates were negotiated, resulting in an average increase in rates of 8.7%. The premiums earned, net and operating income related to the operations of the Metro-North region for the nine months ended September 30, 2006 amounted to $145.8 million and $6.9 million, respectively. The premiums earned, net and operating income related to the operations of the Metro-North region amounted to $161.6 million and $5.4 million, respectively, for the year ended December 31, 2006, and $200.9 million and $3.5 million, respectively, for the year ended December 31, 2005.

	Nine months ended September 30,		Year ended December 31,				
(in millions, except per share data)	**2007**	**2006(1)**	**2006(1)**	**2005**	**2004**	**2003**	**2002**
Statement of Earnings Data							
Revenues:							
Premiums earned, net	$ 1,101.6	$ 1,158.6	$ 1,511.6	$ 1,380.2	$ 1,299.0	$ 1,264.4	$ 1,236.6
Administrative service fees	11.0	10.4	14.1	14.4	9.2	8.3	9.5
Net investment income	33.4	31.3	42.7	29.1	26.8	24.7	24.8
Total operating revenues	1,146.0	1,200.3	1,568.4	1,423.7	1,335.0	1,297.4	1,270.9
Net realized investment gains	6.2	1.3	0.8	7.2	11.0	8.4	0.2
Net unrealized investment gain (loss) on trading securities	(0.8)	3.7	7.7	(4.7)	3.0	14.9	(8.3)
Other income, net	1.8	1.2	2.3	3.7	3.4	4.7	2.1
Total revenues	1,153.2	1,206.5	1,579.2	1,429.9	1,352.4	1,325.4	1,264.9
Benefits and expenses:							
Claims incurred	915.4	974.3	1,259.0	1,208.3	1,115.8	1,065.4	1,062.0
Operating expenses	173.4	170.5	236.1	181.7	171.9	165.1	148.5
Total operating costs	1,088.8	1,144.8	1,495.1	1,390.0	1,287.7	1,230.5	1,210.5
Interest expense	11.9	12.4	16.6	7.6	4.6	3.2	3.6
Total benefits and expenses	1,100.7	1,157.2	1,511.7	1,397.6	1,292.3	1,233.7	1,214.1
Income before taxes	52.5	49.3	67.5	32.3	60.1	91.6	50.8
Income tax expense	11.7	10.5	13.0	3.9	14.3	65.4	2.6

	Nine months ended September 30,		Year ended December 31,				
Net income	$ 40.8	$ 38.8	$ 54.5	$ 28.4	$ 45.8	$ 26.2	$ 48.2

Weighted average number of shares outstanding giving effect to 3,000-for-one stock split	26,741,333	26,728,333	26,733,000	26,712,000	26,757,000	27,540,000	28,593,000
Basic net income per share giving effect to 3,000-for-one stock split	$ 1.53	$ 1.45	$ 2.04	$ 1.06	$ 1.71	$ 0.95	$ 1.69

	As of September 30,	As of December 31,				
(in millions)	**2007**	**2006(1)**	**2005**	**2004**	**2003**	**2002**
Balance Sheet Data						
Cash and cash equivalents	$ 96.0	$ 81.6	$ 49.0	$ 35.1	$ 47.7	$ 82.8
Total assets	1,424.6	1,345.5	1,137.5	919.7	834.6	721.9
Long-term borrowings	171.4	183.1	150.6	95.7	48.4	50.0
Total shareholders' equity	382.9	342.6	308.7	301.4	254.3	231.7

	Nine months ended September 30,		Year ended December 31,				
	2007	**2006**	**2006**	**2005**	**2004**	**2003**	**2002**
Additional Managed Care Data(2)							
Medical loss ratio	87.7%	88.2%	87.6%	90.3%	88.3%	86.6%	87.7%
Operating expense ratio	11.0%	11.0%	11.5%	10.8%	10.8%	10.8%	10.4%
Medical membership (period-end)	977,613	1,189,206	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, Puerto Rico Health Reform (the Reform) and Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans (PDP)) markets. The Reform is a government of Puerto Rico-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 nine months ended September 30, 2007 and the year ended December 31, 2006 respectively, our managed care segment represented approximately 87.9% and 88.6% of our total consolidated premiums earned, net, and approximately 68.9% and 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 had a market share of approximately 15% (in terms of premiums written) as of December 31, 2006. Our property and casualty segment had a market share of approximately 9% (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 and Medicare (including Medicare Advantage and PDP) markets, 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. GA Life and STS represented approximately 6.1% and 6.3%, respectively, of our consolidated premiums earned, net for the nine months ended September 30, 2007 and 14.5% and 11.2%, 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:

(in millions)	Nine months ended September 30, 2007	Nine months ended September 30, 2006	Year ended December 31, 2006	Year ended December 31, 2005	Year ended December 31, 2004
Premiums earned, net					
Managed care	$ 968.2	$ 1,030.6	$ 1,339.8	$ 1,279.5	$ 1,199.2
Life insurance	67.1	64.6	86.9	17.1	16.4
Property and casualty insurance	69.3	66.1	88.5	86.8	86.2
Intersegment premiums earned	(3.0)	(2.7)	(3.6)	(3.2)	(2.8)
Consolidated premiums earned, net	$ 1,101.6	$ 1,158.6	$ 1,511.6	$ 1,380.2	$ 1,299.0

(in millions)	Nine months ended September 30, 2007	Nine months ended September 30, 2006	Year ended December 31, 2006	Year ended December 31, 2005	Year ended December 31, 2004
Administrative service fees					
Managed care	$ 13.5	$ 12.4	$ 16.9	$ 15.5	$ 10.3
Intersegment administrative service fees	(2.5)	(2.0)	(2.8)	(1.1)	(1.1)
Consolidated administrative service fees	$ 11.0	$ 10.4	$ 14.1	$ 14.4	$ 9.2

(in millions)	Nine months ended September 30, 2007	Nine months ended September 30, 2006	Year ended December 31, 2006	Year ended December 31, 2005	Year ended December 31, 2004
Operating income					
Managed care	$ 39.4	$ 33.2	$ 45.5	$ 16.1	$ 36.2
Life insurance	8.3	9.0	11.2	3.0	0.6
Property and casualty insurance	6.5	7.9	11.2	12.3	7.7
Other segments and intersegment eliminations	3.0	5.4	5.4	2.3	2.8
Consolidated operating income	$ 57.2	$ 55.5	$ 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 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 additional terms ending June 30, 2008 and applicable premium rates were negotiated, resulting in an average increase in rates of 8.7%. The premiums earned, net and operating income related to the operations of the Metro-North region for the nine months ended September 30, 2006 amounted to $145.8 million and $6.9 million, respectively. The premiums earned, net 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 (including PDP) and Reform 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 the Centers for Medicare and Medical Services (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 Supplement program to Medicare Advantage plans offered by our competitors and, to a lesser extent, ourselves. Membership in our Reform program has also been affected by the shifting of Reform program members to such Medicare Advantage plans.

We believe that the Medicare Advantage program (including PDP) provides 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. The membership in our Medicare Advantage programs increased by 36.7% in the first nine months of 2007; from 27,078 members as of December 31, 2006 to 37,022 as of September 30, 2007. In January 2006, we launched our stand-alone PDP plan, *FarmaMed*, which as of September 30, 2007, had 11,269 members. We expect that Medicare Advantage enrollment will continue to experience growth, but at a slower pace than in this initial period.

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

	As of September 30,		As of December 31,		
	2007	2006	2006	2005	2004
Commercial(1)	576,600	589,785	580,850	612,218	621,665
Reform(2)	352,722	554,996	357,515	628,438	614,443
Medicare Advantage(3)	48,291	44,425	41,141	11,993	
Total	977,613	1,189,206	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 as of September 30, 2006 and as of December 31, 2005 and 2004 includes the Metro-North region. The contract for this region was not renewed effective November 1, 2006.

(3) Includes Medicare Advantage as well as stand-alone PDP plan membership.

Consolidated Operating Results

The following table sets forth our consolidated operating results for the nine-month periods ended September 30, 2007 and 2006 and the years ended December 31, 2006, 2005 and 2004.

	Nine months ended September 30,		Year ended December 31,			
(in millions)	**2007**	**2006(1)**	**2006(1)**	**Comparable Basis 2005(2)**	**2005**	**2004**
Revenues:						
Premiums earned, net	$ 1,101.6	$ 1,158.6	$ 1,511.6	$ 1,441.8	$ 1,380.2	$ 1,299.0
Administrative service fees	11.0	10.4	14.1	14.4	14.4	9.2
Net investment income	33.4	31.3	42.7	39.7	29.1	26.8
Total operating revenues	1,146.0	1,200.3	1,568.4	1,495.9	1,423.7	1,335.0
Net realized investment gains	6.2	1.3	0.8	11.6	7.2	11.0
Net unrealized investment gain (loss) on trading securities	(0.8)	3.7	7.7	(4.7)	(4.7)	3.0
Other income, net	1.8	1.2	2.3	3.7	3.7	3.4
Total revenues	1,153.2	1,206.5	1,579.2	1,506.5	1,429.9	1,352.4
Benefits and expenses:						
Claims incurred	915.4	974.3	1,259.0	1,237.3	1,208.3	1,115.8
Operating expenses	173.4	170.5	236.1	213.2	181.7	171.9
Total operating costs	1,088.8	1,144.8	1,495.1	1,450.5	1,390.0	1,287.7
Interest expense	11.9	12.4	16.6	9.0	7.6	4.6
Total benefits and expenses	1,100.7	1,157.2	1,511.7	1,459.5	1,397.6	1,292.3
Income before taxes	52.5	49.3	67.5	47.0	32.3	60.1
Income tax expense	11.7	10.5	13.0	3.1	3.9	14.3
Net income	$ 40.8	$ 38.8	$ 54.5	$ 43.9	$ 28.4	$ 45.8

(1) The 2006 historical results of operations of GA Life are included in this table for the period following January 31, 2006, the effective date of the acquisition.

(2) 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 audited 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.

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Nine months ended September 30, 2007 compared with nine months ended September 30, 2006

Operating Revenues

Consolidated premiums earned, net and administrative service fees decreased by $56.4 million, or 4.8%, to $1,112.6 million during the nine months ended September 30, 2007 compared to the nine months ended September 30, 2006. The decrease was primarily due to a decrease in the premiums earned, net in our managed care segment, principally due to the decreased volume of the Reform business after the termination of the contract for the Metro-North region, offset in part by the growth of our Medicare Advantage business and the increases in premium rates of the Reform business during 2007.

Consolidated net investment income increased by $2.1 million, or 6.7%, to $33.4 million during the nine months ended September 30, 2007. This increase is primarily the result of an increase of $1.1 million attributed to a higher yield in 2007 and a higher balance of invested assets and the acquisition of GA Life effective January 31, 2006. Net investment income earned by GA Life during the month of January 2006 amounted to $1.0 million, which is not included in our consolidated financial statements.

Net realized investment gains

Consolidated net realized investment gains increased by $4.9 million to $6.2 million during the nine months ended September 30, 2007. This increase is primarily the result of higher sales in 2007 of investments, particularly in trading securities, in order to keep the portfolio within our established targets in each investment sector.

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

The combined balance of our consolidated net unrealized gain (loss) on trading securities and other income, net decreased by $3.9 million, to a gain of $1.0 million during the nine months ended September 30, 2007. The decrease is primarily the net result of an increase in the fair value of the derivative component of our investment in structured notes linked to foreign stock indexes, offset in part by the unrealized loss on the trading portfolio. This unrealized loss on trading securities is due to the sale of one equity portfolio which had a net unrealized gain at the time of sale. This sale had the effect of eliminating the unrealized gain that was offsetting unrealized losses in our trading portfolio.

Claims Incurred

Consolidated claims incurred during the nine months ended September 30, 2007 decreased by $58.9 million, or 6.0%, to $915.4 million when compared to the claims incurred during the nine months ended September 30, 2006. This decrease is principally due to decreased claims in the managed care segment as a result of the decreased volume of the Reform business due to the termination of the contract for the Metro-North region, net of increased enrollment in the Medicare Advantage business. The consolidated loss ratio decreased by 1.0 percentage points, to 83.1% in the 2007 period. The lower loss ratio is mainly the result of an overall increase in premium rates and a change in the mix of business. During the nine months ended September 30, 2007, the weight in the mix of business of the managed care segment corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher loss ratio than other businesses within this segment. On the other hand, the Medicare Advantage business, which has a lower loss ratio than other businesses within the managed care segment, has a higher weight in the mix of business in the 2007 period.

Operating Expenses

Consolidated operating expenses during the nine months ended September 30, 2007 increased by $2.9 million, or 1.7%, to $173.4 million as compared to operating expenses during the 2006 period. This increase is primarily attributed to increases in professional services expense (mainly legal expenses), normal increases in payroll and payroll related expense, as well as higher technology related costs due to the new systems initiative of our managed care subsidiary. This increase is offset in part by the decrease in the operating expenses for the Reform business resulting from the reduction in volume of this business. The consolidated operating expense ratio increased by 1.0 percentage points during the 2007 period mainly due to fixed expenses not affected by a reduction in volume.

Income tax expense

The consolidated effective tax rate increased by 1.0 percentage points, from 21.3% in 2006 to 22.3% in 2007, primarily due to a higher taxable income in 2007 from our managed care segment, which has a higher effective tax rate than our other segments.

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 the operating revenues of our managed care segment, which was attributable principally 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 was 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 was primarily the 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, which was 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.

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. For the nine months ended September 30, 2007, the Commercial sector represented 48.9% and 3.8% of our consolidated premiums earned, net and operating income, respectively. During the same period, the Reform sector represented 22.1% and 15.6% of our consolidated premiums earned, net and our operating income, respectively. Premiums earned, net and operating income generated from our Medicare Advantage

contracts (including PDP) during the nine months ended September 30, 2007 represented 16.9% and 49.5% of our consolidated earned premiums, net and our operating income, respectively.

(in millions)	Nine months ended September 30,		Year ended December 31,		
	2007	2006	2006	2005	2004
Medical operating revenues:					
Medical premiums earned, net:					
Commercial	$ 538.7	$ 540.7	$ 713.2	$ 734.5	$ 714.5
Reform	243.8	366.7	455.8	510.8	484.7
Medicare Advantage	185.7	123.2	170.8	34.2	
Medical premiums earned	968.2	1,030.6	1,339.8	1,279.5	1,199.2
Administrative service fees	13.5	12.4	16.9	15.5	10.3
Net investment income	14.3	13.9	18.8	17.0	16.0
Total medical operating revenues	996.0	1,056.9	1,375.5	1,312.0	1,225.5
Medical operating costs:					
Medical claims incurred	848.9	909.4	1,173.6	1,155.9	1,058.6
Medical operating expenses	107.7	114.3	156.4	140.0	130.7
Total medical operating costs	956.6	1,023.7	1,330.0	1,295.9	1,189.3
Medical operating income	$ 39.4	$ 33.2	$ 45.5	$ 16.1	$ 36.2
Additional data:					
Member months enrollment:					
Commercial:					
Fully-insured	3,743,350	3,995,526	5,272,987	5,632,249	5,755,380
Self funded	1,447,287	1,387,341	1,861,833	1,840,716	1,692,108
Total Commercial member months	5,190,637	5,382,867	7,134,820	7,472,965	7,447,488
Reform	3,199,546	5,211,533	6,484,270	7,465,777	7,377,048
Medicare Advantage	407,675	327,289	461,718	71,947	
Total member months	8,797,858	10,921,689	14,080,808	15,010,689	14,824,536
Medical loss ratio	87.7%	88.2%	87.6%	90.3%	88.3%
Operating expense ratio	11.0%	11.0%	11.5%	10.8%	10.8%

Nine months ended September 30, 2007 compared with nine months ended September 30, 2006

Medical Operating Revenues

Medical premiums earned for the nine months ended September 30, 2007 decreased by $62.4 million, or 6.1%, to $968.2 million when compared to the medical premiums earned during the nine months ended September 30, 2006, principally as a result of the following:

Medical premiums earned in the Reform business decreased by $122.9 million, or 33.5%, to $243.8 million during the 2007 period. This fluctuation is due to a decrease in member months enrollment in the Reform business by 2,011,987, or 38.6%, mainly as the result of the termination of the contract for the Metro-North region, the tightening of membership restrictions by the Puerto Rico government, and the shift in membership of dual eligibles to Medicare Advantage policies offered by us and our competitors. The member months enrollment of the Metro-North region was 1,841,815 during the nine months ended

September 30, 2006. The effect of this decrease in membership was mitigated by an increase in premium rates, effective July 1, 2007, of approximately 8.7% and a retroactive increase in rates of approximately 6.7% effective November 1, 2006.

Medical premiums generated by the Commercial business decreased by $2.0 million, or 0.4%, to $538.7 million during the 2007 period. This decrease is primarily the result of a decrease in member months enrollment of 252,176, or 6.3%, partially offset by an increase in average premium rates of 6.3%.

Medical premiums generated by the Medicare Advantage business increased during the nine months ended September 30, 2007 by $62.5 million, or 50.7%, to $185.7 million, primarily due to an increase in member months enrollment of 80,386, or 24.6%. The increase in member months is the net result of an increase of 110,540, or 57.2%, in the membership of our Medicare Advantage products and

a decrease of 30,154, or 22.5%, in the membership of our PDP product. We expect that Medicare Advantage enrollment will continue to experience growth, but at a slower pace than in prior periods. In addition, the segment recognized an additional premium adjustment of $3.2 million related to the 2006 risk scores review performed by CMS.

Administrative service fees increased by $1.1 million, or 8.9%, to $13.5 million during the 2007 period due to an increase in member months enrollment of self-funded arrangements of 59,946, or 4.3% and to a shift of several self-funded groups to arrangements where the administrative service fee is based on contracts instead of claims paid.

Medical Claims Incurred

Medical claims incurred during the nine months ended September 30, 2007 decreased by $60.5 million, or 6.7%, to $848.9 million when compared to the nine months ended September 30, 2006. The decrease in medical claims incurred is mostly related to the medical claims incurred of the Reform business, which decreased by $112.3 million due to its decreased enrollment, partially offset by a combined increase of $53.4 million in the medical claims incurred of the Medicare Advantage and PDP businesses due to an increase in members. The medical loss ratio decreased by 0.5 percentage points during the 2007 period, to 87.7%, primarily due to an overall increase in premium rates and a change in the mix of business of the segment. During the nine months ended September 30, 2007 the weight in the mix of business corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher medical loss ratio than other businesses within the segment. On the other hand, the Medicare Advantage business, which has a lower medical loss ratio than other businesses, had a higher weight in the mix of business in the 2007 period.

Medical Operating Expenses

Medical operating expenses for the nine months ended September 30, 2007 decreased by $6.6 million, or 5.8%, to $107.7 million when compared to the nine months ended September 30, 2006. This decrease is primarily attributed to the decrease in the direct costs of the Reform business due to its reduction in volume. The segment's operating expense ratio remained the same as the prior period at approximately 11.0%.

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 growth, but at a slower pace than in this initial period.

In January 2006, we introduced a new PDP product, *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 government of Puerto Rico. 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 was 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 was 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 was 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 was 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 was 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

(in millions)	Nine months ended September 30,		Year ended December 31,			
	2007	2006(1)	2006(1)	Comparable Basis 2005(2)	2005	2004
Operating revenues:						
Premiums earned, net						
Premiums earned	$ 73.5	$ 67.2	$ 91.9	$ 87.9	$ 24.2	$ 23.7
Premiums earned ceded	(6.6)	(7.1)	(9.7)	(10.1)	(8.0)	(7.8)
Assumed premiums earned		4.4	4.4	0.4	0.4	
Net premiums earned	66.9	64.5	86.6	78.2	16.6	15.9
Commission income on reinsurance	0.2	0.1	0.3	0.5	0.5	0.5
Premiums earned, net	67.1	64.6	86.9	78.7	17.1	16.4
Net investment income	11.1	10.1	13.7	13.6	3.0	2.8
Total operating revenues	78.2	74.7	100.6	92.3	20.1	19.2
Operating costs:						
Policy benefits and claims incurred	34.4	32.4	43.6	37.9	8.9	11.2
Underwriting and other expenses	35.5	33.3	45.8	39.7	8.2	7.4
Total operating costs	69.9	65.7	89.4	77.6	17.1	18.6
Operating income	$ 8.3	$ 9.0	$ 11.2	$ 14.7	$ 3.0	$ 0.6
Additional data:(3)						
Loss ratio	51.3%	50.2%	50.2%	48.2%	52.0%	68.3%
Operating expense ratio	52.9%	51.5%	52.7%	50.4%	48.0%	45.1%

(1) The 2006 historical results of operations of GA Life are included in this table for the period following January 31, 2006, the effective date of the acquisition.

(2) 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.

(3) Based on premiums to claims and expenses only. Investment income is not included in ratio.

Nine months ended September 30, 2007 compared with nine months ended September 30, 2006

Operating Revenues

Premiums earned for the segment increased by $6.3 million, or 9.4%, to $73.5 million during the nine months ended September 30, 2007 as compared to the nine months ended September 30, 2006, principally reflecting the acquisition of GA Life effective January 31, 2006. Premiums earned by GA Life during the month of January 2006 were $6.6 million, which are not reflected in our consolidated financial statements. Eliminating the effect of GA Life's premiums for the month of January 2006, the premiums earned in the segment decreased by $0.3 million. During the nine months ended September 30, 2007, the premiums generated by the segment's group disability and group life businesses decreased by $1.6 million and $0.8 million, respectively, offset in part by an increase in the individual life and cancer businesses of $1.6 million and $0.5 million, respectively.

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 during the nine months ended September 30, 2007 increased by $2.0 million, or 6.2%, to $34.4 million in the 2007 period when compared to the 2006 period, principally reflecting the acquisition of GA Life effective January 31, 2006. Policy benefits and claims incurred by GA Life during the month of January 2006, net of the effect of the coinsurance agreement, were $1.0 million. Eliminating the effect of GA Life's policy benefits and claims incurred for the month of January 2006, this segment presented an increase of $1.0 million. This increase is primarily driven by increases in the benefits of the cancer and group life business of $1.5 million and $1.0 million, respectively, and to an increase in policy surrenders of $0.7 million. These increases were partially offset by decreases in the benefits of the group disability and individual life businesses of $1.0 million in each business. The segment's loss ratio increased by 1.1 percentage points, from 50.2% in 2006 to 51.3% in 2007, principally as a result of the inclusion of nine months of GA Life benefits and claims incurred in the 2007 period and a higher loss ratio in the cancer business.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $2.2 million, or 6.6%, during the nine months ended September 30, 2007. Considering the effect of underwriting and other expenses of $1.7 million incurred by GA Life during the month of January 2006, net of the effect of the coinsurance agreement, the underwriting and other expenses of the segment increased $0.5 million. This is mostly related to a higher allocation of corporate operating expenses.

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 was 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.

Our results reflect $4.4 million of premiums assumed under the coinsurance funds withheld agreement with GA Life, 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 was 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 recorded assumed premiums amounting to $0.4 million related to the coinsurance funds withheld reinsurance agreement with GA Life.

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

(in millions)	Nine months ended September 30,		Year ended December 31,		
	2007	2006	2006	2005	2004
Operating revenues:					
Premiums earned, net:					
Premiums written	$ 117.3	$ 112.6	$ 158.9	$ 151.1	$ 141.8
Premiums ceded	(50.3)	(46.7)	(65.7)	(59.2)	(52.2)
Change in unearned premiums	2.3	0.2	(4.7)	(5.1)	(3.4)
Premiums earned, net	69.3	66.1	88.5	86.8	86.2
Net investment income	7.6	7.0	9.6	8.7	7.7
Total operating revenues	76.9	73.1	98.1	95.5	93.9
Operating costs:					
Claims incurred	32.1	32.5	41.7	43.6	46.0
Underwriting and other operating expenses	38.4	32.7	45.2	39.6	40.2
Total operating costs	70.5	65.2	86.9	83.2	86.2
Operating income	$ 6.4	$ 7.9	$ 11.2	$ 12.3	$ 7.7
Additional data:(1)					
Loss ratio	46.3%	49.2%	47.1%	50.2%	53.4%
Operating expense ratio	55.4%	49.5%	51.1%	45.6%	46.6%
Combined ratio	101.7%	98.7%	98.2%	95.8%	100.0%

(1) Based on premiums to claims and expenses only. Investment income is not included in ratio.

Nine months ended September 30, 2007 compared with nine months ended September 30, 2006

Operating Revenues

Total premiums written during the nine months ended September 30, 2007 increased by $4.7 million, or 4.2%, to $117.3 million, principally as a result of an increase in the commercial multi-peril and auto lines of business.

Premiums ceded to reinsurers increased by $3.6 million, or 7.7%, to $50.3 million during 2007. The ratio of premiums ceded to premiums written increased by 1.4 percentage points, from 41.5% in 2006 to 42.9% in 2007, primarily as the result of higher costs of non-proportional reinsurance treaties and to the increase in the volume of business of the segment in lines of business that have reinsurance.

The increase in the change in unearned premiums of $2.1 million, to $2.3 million, during the nine months ended September 30, 2007 is principally the result of the segment's lower volume of business during the last three months of the nine-month period ended September 30, 2007, which caused an increase in the amortization of unearned premiums.

Claims Incurred

Claims incurred during the nine months ended September 30, 2007 decreased by $0.4 million, or 1.2%, to $32.1 million. The loss ratio decreased by 2.9 percentage points during this period, to 46.3% in the 2007 period, primarily as a result of the segment's adherence to underwriting guidelines and enhancements to the claims handling process, which included hiring additional in-house claim adjusters. These efforts have resulted in improved loss ratios in the commercial multi-peril, general liability, auto liability and commercial auto physical damage lines of business.

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Underwriting and Other Expenses

Underwriting and other operating expenses for the nine months ended September 30, 2007 increased by $5.7 million, or 17.4%, to $38.4 million. The operating expense ratio increased by 5.9 percentage points during the same period, to 55.4% in 2007. This increase is primarily due to increases in net commission expense, payroll and payroll related expenses, and in provision for a possible contingency. The segment has also experienced an increase in its depreciation expense, including the depreciation and amortization expense related to the segment's investment in technology, and in the allocation of corporate operating expenses.

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 was 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 were 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:

	Nine months ended September 30,		Year ended December 31,		
(in millions)	**2007**	**2006**	**2006**	**2005**	**2004**
Sources of cash:					
Cash provided by operating activities	$ 51.5	$ 51.1	$ 73.7	$ 49.1	$ 8.8
Proceeds from long-term borrowings		35.0	35.0	60.0	50.0
Proceeds from short-term borrowings	43.6	117.8	117.8	174.1	20.4
Proceeds from policyholder deposits	5.1	4.4	6.0	11.5	11.0
Other	17.4	0.4		3.9	6.8
Total sources of cash	117.6	208.7	232.5	298.6	97.0
Uses of cash:					
Net purchases of investment securities	(33.3)	(18.8)	(7.6)	(92.9)	(41.5)
Acquisition of GA Life, net of cash acquired		(27.8)	(27.8)		
Capital expenditures	(6.3)	(9.5)	(11.9)	(7.6)	(3.5)
Dividends	(2.4)	(6.2)	(6.2)		
Payments of long-term borrowings	(11.7)	(2.1)	(2.5)	(5.1)	(2.6)
Payments of short-term borrowings	(43.6)	(119.5)	(119.5)	(174.0)	(57.4)
Surrenders of policyholder deposits	(5.6)	(10.2)	(16.0)	(5.1)	(4.6)
Other	(0.3)	(0.5)	(8.7)		
Total uses of cash	(103.2)	(194.6)	(200.2)	(284.7)	(109.6)
Net increase (decrease) in cash and cash equivalents	$ 14.4	$ 14.1	$ 32.3	$ 13.9	$ (12.6)

Nine months ended September 30, 2007 compared to nine months ended September 30, 2006

Cash flows from operating activities increased by $0.4 million, or 0.8%, to $51.5 million for the nine months ended September 30, 2007, principally due to the net effect of a reduction in cash paid to suppliers and employees of $7.5 million, a reduction in claims paid of $48.0 million and a reduction in premiums collected of $55.0 million, that is mainly attributed to the termination of the contract for the Metro-North region of our Managed Care segment. In addition, in the 2007 period there was an increase of $21.7 million in the amount of income taxes paid that is the result of the higher taxable income in 2007 of our managed care subsidiary, which has a higher effective tax rate than the other segments. These decreases are offset in part by an increase of $19.6 million in net proceeds received from trading securities.

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.

The increase in other sources of cash of $17.0 million is principally the result of a higher balance in outstanding checks over bank balance in the 2007 period.

Net purchases of investment securities increased by $14.5 million during the 2007 period, primarily as the result of purchases of investments classified as available-for-sale securities with the net proceeds obtained from trading securities.

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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 decreased by $3.2 million as a result of the completion of a building adjacent to our corporate headquarters which was completed during the last quarter of the year 2006. In addition, our property and casualty insurance segment acquired new hardware and software as part of its new insurance application during 2006.

In March 2007, we declared and paid dividends to our stockholders amounting to $2.4 million.

We repaid the outstanding balance of $10.5 million of one of our secured term loans upon its maturity on August 1, 2007.

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 policyholder deposits of $10.0 million while the 2005 period presents net proceeds from annuity contracts of $6.4 million. This fluctuation was principally due to an increase in the amount of policyholder deposit surrenders and a decrease in the proceeds received from the fixed deferred policyholder deposits 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 September 30, 2007, we had $53.0 million of available credit under these facilities. There were no outstanding short-term borrowings under these facilities as of September 30, 2007 or December 31, 2006.

As of September 30, 2007, 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 6.3% notes, the 6.6% notes and the 6.7% notes contain certain covenants. At September 30, 2007, we and our managed care subsidiary, as applicable, are in compliance with these covenants.

In addition, as of September 30, 2007 we are a party to a secured term loan with a commercial bank, FirstBank Puerto Rico. This secured loan bears interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus 100 basis points and requires monthly principal repayment of $0.1 million.

As of September 30, 2007, this secured loan had an outstanding balance of $26.4 million and an average annual interest rate of 6.4%.

This secured loan is 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. This secured loan contains 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 September 30, 2007, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loan's outstanding balance. Principal repayments on this loan 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 were also a party to another secured loan whose outstanding balance of $10.5 million was repaid upon its maturity on August 1, 2007. The average annual interest rate of this secured loan was 6.7%.

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 be carried out in phases until 2013 at a cost of approximately $40.0 million. Our managed care business expects to incur costs of approximately $4.0 million during 2007, all of which will be expensed as incurred. This amount is expected to be paid out of the operating cash flows of our managed care business. The costs during this initial phase relate principally to temporary licensing and professional service fees to evaluate our business needs. This phase will provide management with an estimate of the timing, extent and costs related to the project, prior to committing to a long-term licensing agreement.

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 as of December 31, 2006, 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 and September 30, 2007, our liability for future policy benefits amounted to $180.4 million and $190.5 million, respectively.

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 and

September 30, 2007, we had $113.6 million and $98.8 million in unearned premiums, respectively.

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 and September 30, 2007, our policyholder deposits had a carrying amount of $45.4 million and $46.1 million, respectively.

Other long-term liabilities Due to the indeterminate timing of their cash outflows, as of December 31, 2006 and September 30, 2007, $56.2 million and $51.9 million, respectively, of other long-term liabilities are not reflected in the following table, including $32.3 million and $30.7 million, respectively, of liability for pension benefits and $13.6 million and $19.6 million, respectively, in liabilities to the Federal Employees Health Benefit Plan.

	Contractual obligations for the years ended December 31,						
(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

(1) As of September 30, 2007, our long-term borrowings consist of our managed care subsidiary's 6.3% senior unsecured notes payable (which are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us), our 6.6% senior unsecured notes payable, our 6.7% senior unsecured notes payable, and a loan payable to a commercial bank. Total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.3%, 6.6% and 6.7% 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 September 30, 2007, 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 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 risk-based capital (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 September 30, 2007, our and our managed care subsidiary's RBC ratios were 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 government of Puerto Rico 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. During the nine months ended September 30, 2007, no assessment or payment was made in connection with insurance companies declared insolvent. 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 the nine months ended September 30, 2007 and during the years 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 nine months ended September 30, 2007 and during the years 2006, 2005 and 2004, the Association distributed a dividend based on the good experience of the business amounting to $1.0 million, $0.8 million, $0.9 million and $0.8 million, 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 September 30, 2007 by segment were as follows:

(in millions)	Managed Care	Life Insurance	Property and Casualty Insurance	Consolidated
Claims processed and incomplete(1)	$ 76.7	$ 26.8	$ 65.4	$ 168.9
Unreported losses(2)	120.4	8.4	33.6	162.4
Unpaid loss-adjustments expenses(3)	5.3	0.3	11.6	17.2
	$ 202.4	$ 35.5	$ 110.6	$ 348.5

(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 September 30, 2007, claim liabilities for the managed care segment amounted to $202.4 million and represented 58.1% of our total consolidated claim liabilities and 19.4% 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 78% of the outstanding claims are paid within three months after the last day of the month in which they were incurred and about 11% are paid within six months after the last day of the month in which they were incurred, for a total of 89% paid within six months after the last day of the month in which they were incurred.

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 condition 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:

(in millions)

Completion Factor(1)		Claims Trend Factor(2)	
(Decrease) Increase		(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.

(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)	1,163.6	1,137.5	1,070.4	1,021.9
Variance	$ 20.7	$ 10.7	$ (7.7)	$ 4.1
Variance to total incurred claims as reported	1.8%	0.9%	(0.7)%	0.4%

(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 nine-month period ended September 30, 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 September 30, 2007, claim liabilities for the life insurance segment amounted to $35.5 million and represented 10.2% of total consolidated claim liabilities and 3.4% of our total consolidated liabilities.

The claim liabilities related to the life insurance segment are based on methods and underlying assumptions in accordance with U.S. GAAP and applicable actuarial standards of practice. 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 September 30, 2007, claim liabilities for the property and casualty insurance segment amounted to $110.6 million and represented 31.7% of the total consolidated claim liabilities and 10.6% 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 nine-month period ended September 30, 2007 and 2006, we recognized other-than-temporary impairments of $0.6 million and $1.4 million, respectively, on our equity securities classified as available for sale. 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 September 30, 2007, of the total amount of investments in securities of $918.3 million, $70.0 million, or 7.6%, 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 $848.3 million is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $673.1 million, or 79.3%, 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 government of Puerto Rico instrumentalities. The remaining $175.2 million, or 20.7%, are from corporate fixed and equity securities. Gross unrealized losses as of September 30, 2007 of the available-for-sale and held-to-maturity portfolios amounted to $12.2 million.

The impairment analysis as of September 30, 2007 and December 31, 2006 indicated that, other than the equity securities 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".

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 the notes to our 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 $20.1 million and $18.2 million as of September 30, 2007 and December 31, 2006, 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.

The board of directors monitors and approves investment policies and procedures. Investment decisions are centrally managed by investment professionals based on the guidelines established in our investment policies and procedures. 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 73% and 76% of the total portfolio value as of September 30, 2007 and December 31, 2006, respectively, of which 10% and 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 September 30, 2007 and 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 September 30, 2007 and December 31, 2006, the hypothetical loss in the fair value of these investments would have been approximately $7.0 million and $8.3 million, respectively.

Other than Trading Portfolio

Our available-for-sale and held-to-maturity securities are also a source of market risk. As of September 30, 2007, approximately 91% and 100% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed income securities. 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 as of September 30, 2007 and December 31, 2006 and 2005.

(in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
September 30, 2007:			
Base Scenario	$ 774.2		
+100 bp	735.4	(38.8)	(5.0)%
+200 bp	703.0	(71.2)	(9.2)%
+300 bp	669.9	(104.3)	(13.5)%
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)%