Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 09/01/2024 and ending 08/31/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
TRANS OCEANIC LIFE INSURANCE DENTAL PLAN

1b Three-digit plan number (PN) ▶ 501

1c Effective date of plan 09/01/2003

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
TRANS OCEANIC LIFE INSURANCE COMPAN

PO BOX 363467
SAN JUAN, PR 00936-3467

PO BOX 363467
SAN JUAN, PR 00936-3467

2b Employer Identification Number (EIN) 66-0235829

2c Plan Sponsor's telephone number 787-620-2680

2d Business code (see instructions) 524140

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	03/02/2026	EDRICK TOUMA
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	03/02/2026	EDRICK TOUMA
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor	**3b** Administrator's EIN	
	3c Administrator's telephone number	
4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report: **a** Sponsor's name **c** Plan Name	**4b** EIN **4d** PN	
5 Total number of participants at the beginning of the plan year	**5**	118
6 Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1) Total number of active participants at the beginning of the plan year	**6a(1)**	118
a(2) Total number of active participants at the end of the plan year	**6a(2)**	116
b Retired or separated participants receiving benefits	**6b**	
c Other retired or separated participants entitled to future benefits	**6c**	
d Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	116
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f Total. Add lines **6d** and **6e**.	**6f**	116
g(1) Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2) Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7 Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4D

9a Plan funding arrangement (check all that apply)	**9b** Plan benefit arrangement (check all that apply)
(1) [X] Insurance	**(1)** [X] Insurance
(2) [ ] Code section 412(e)(3) insurance contracts	**(2)** [ ] Code section 412(e)(3) insurance contracts
(3) [ ] Trust	**(3)** [ ] Trust
(4) [ ] General assets of the sponsor	**(4)** [ ] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 09/01/2024 and ending 08/31/2025

A Name of plan
TRANS OCEANIC LIFE INSURANCE DENTAL PLAN

B Three-digit plan number (PN) ▶ 501

C Plan sponsor's name as shown on line 2a of Form 5500
TRANS OCEANIC LIFE INSURANCE COMPAN

D Employer Identification Number (EIN)
66-0235829

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions** Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
DELTA DENTAL OF PUERTO RICO, INC.

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
68-0652604	52411	0924	102	09/01/2024	08/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
2305	

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

MARSH PUERTO RICO
PO BOX 9023549
SAN JUAN, PR 00902

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
2305		BROKER	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [ ] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**	35743		
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	35743
b Benefit charges (1) Claims paid	**9b(1)**	27436		
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	27436
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**	2305		
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	2305
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			**10b**	

Specify nature of costs.

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

DELTA DENTAL

INSURANCE CERTIFICACION
SCHEDULE A
(FORM 5500)

PART I : COVERAGE

NAME OF INSURANCE CARRIER:	**DELTA DENTAL OF PUERTO RICO, INC.**
SOCIAL SECURITY NO. OR ID NUMBER:	68-0652604
NAIC CODE:	52411
POLICY NAME:	**TRANS OCEANIC LIFE INSURANCE**
POLICY PERIOD:	From: **9/1/2024** To: **8/31/2025**
CONTRACT OR POLICY NUMBER:	GROUP NO: **924**
APPROXIMATE # OR PERSONS COVERED AT THE END OF POLICY OR CONTRACT YEAR:	EMPLOYEES **102**
POLICY OR CONTRACT YEAR:	**9/1/2024** **8/31/2025**

PART II: COMMISSIONS / FEES

a) AGENT NAME:	**MARSH SALDAÑA**
	NONE
b) COMMISSIONS AMOUNT:	**$ 2,305.41**

PART III: WELFARE BENEFITS CONTRACT

TYPE OF BENEFIT:	**DENTAL PLAN**
LIST PAID PREMIUMS FOR EACH CONTRACT:	**$ 35,742.76**
LIST PAID CLAIMS FOR EACH CONTRACT:	**$ 27,436.22**

MONTHLY RATES:

	LOCAL 0001, 0002, 9991, 9992	**LOCAL 0003**
SINGLE:	**$ 17.34**	**$ 29.56**
COUPLE:	**$ 30.14**	**$ 59.13**
FAMILY:	**$ 45.56**	**$ 70.95**

Authorized by:

Rosaly Flores

Note to policyholders: The information certified above is furnished to enable the plan administrator to complete Schedule A (Form 5500) required by the Internal Revenue Services. Some of the terms used in the official form are susceptible to different interpretations. Therefore the plan administrator is responsible for verifying the accuracy of the information provided and for complimenting the Schedule with other information for which Delta Dental of PR Inc. has no information available. For further information about filing, please contact your attorney or tax consultant.

		I:	18.55
Aumento:	**7%**	P:	32.25
		F:	48.75

DPO- AGENT CARPENTINO RTS CHG 9/2009 / EDRICK TOUMA, VP OPERACIONES etouma@tolic.com /Natasha Hernández nhernandez@tolic.com

DDPR Group Premiums & Paid Claims History

Comment:

Group Name:	TRANS OCEANIC LIFE INSURANCE			**Program:**	**PPO**
				Renewal date:	**Sep-26**
Group Number:	**924**	**Employees:**	**108**	**Eff Date:**	**Jul-98**
Renewal Month:	**September**	**PEPM**	**$21.24**	**Term. Date**	**N/A**

A/B1:	**MARSH SALDAÑA**
A/B2:	**NONE**

Administrative Charge:

Delta Dental PR	**18.30%**	$6,540.93
Commission:	**6.45%**	$2,305.41
Comm 2:	**0.00%**	$0.00
Comm2 BK:	**0.00%**	$0.00
	24.75%	**$8,846.33**

Loss Ratio:	**101.51%**
Claims / Premium:	**76.76%**
Claims / Premium/comm:	**83.21%**

	EE's	Invoice	Premium Received	Premium Received minus Invoice	Paid Claims	# of claims	Claims & Charge
Sep-24	114	$0.00	$3,099.51		$2,768.00	27	$3,535.13
Oct-24	113	$0.00	$3,103.93		$4,204.55	36	$4,972.77
Nov-24	111	$0.00	$3,277.33		$1,824.19	25	$2,635.33
Dec-24	109	$0.00	$3,018.05		$1,723.96	34	$2,470.93
Jan-25	109	$0.00	$2,940.43		$1,212.82	19	$1,940.58
Feb-25	106	$0.00	$2,963.53		$1,704.12	23	$2,437.59
Mar-25	107	$0.00	$2,845.87		$2,591.92	32	$3,296.27
Apr-25	106	$0.00	$3,012.81		$3,773.62	30	$4,519.29
May-25	107	$0.00	$2,914.13		$2,416.02	32	$3,137.27
Jun-25	105	$0.00	$2,865.83		$2,370.84	30	$3,080.13
Jul-25	103	$0.00	$2,816.95		$1,603.99	24	$2,301.19
Aug-25	102	$0.00	$2,884.39		$1,242.19	17	$1,956.08
	1292	0.00		$0.00	$27,436.22	329	
			$35,742.76				**$36,282.55**
Billing Amount			$8,306.54		-$8,306.54		-$539.79

Loc: **0001** **PREVIEWS YEAR**

NOTE:

DATA AS OF **01/20/26**

D&P	A	100	100	**DELTAVISION:**
R	B	80	80	
PR	C1	50	50	
PF	C2	50	50	
	Max:	1000	1000	
O	D	50	50	
	Max:	1000	1000	
	D. (A)			
	D / I	0	0	
	D / F	0	0	
I	**55**	$17.34	$17.34	
P	**15**	$30.14	$30.14	
F	**20**	$45.56	$45.56	
E+D1	**12**	$30.14	$30.14	
E+D+	**6**	$45.56	$45.56	

TRANS OCEANIC LIFE INSURANCE

DDPPR Group Premiums & Paid Claims History

Group Number: 924
Group Name: TRANS OCEANIC LIFE INSURANCE
Renewal Month: 9/1/2024
Agent / Broker: MARSH SALDAÑA

Employees: 102
Effective Date:
Commission: 6.45%

	EE's	Premium Received	% Commission	Commission	Agent Name 1	Agent Name 2	Paid Claims
Sep-24	114	$ 3,099.51	6.45%	$ 199.92	MARSH SALDAÑA	NONE	$ 2,768.00
Oct-24	113	$ 3,103.93	6.45%	$ 200.20	MARSH SALDAÑA	NONE	$ 4,204.55
Nov-24	111	$ 3,277.33	6.45%	$ 211.39	MARSH SALDAÑA	NONE	$ 1,824.19
Dec-24	109	$ 3,018.05	6.45%	$ 194.66	MARSH SALDAÑA	NONE	$ 1,723.96
Jan-25	109	$ 2,940.43	6.45%	$ 189.66	MARSH SALDAÑA	NONE	$ 1,212.82
Feb-25	106	$ 2,963.53	6.45%	$ 191.15	MARSH SALDAÑA	NONE	$ 1,704.12
Mar-25	107	$ 2,845.87	6.45%	$ 183.56	MARSH SALDAÑA	NONE	$ 2,591.92
Apr-25	106	$ 3,012.81	6.45%	$ 194.33	MARSH SALDAÑA	NONE	$ 3,773.62
May-25	107	$ 2,914.13	6.45%	$ 187.96	MARSH SALDAÑA	NONE	$ 2,416.02
Jun-25	196	$ 2,865.83	6.45%	$ 184.85	MARSH SALDAÑA	NONE	$ 2,370.84
Jul-25	198	$ 2,816.95	6.45%	$ 181.69	MARSH SALDAÑA	NONE	$ 1,603.99
Aug-25	102	$ 2,884.39	6.45%	$ 186.04	MARSH SALDAÑA	NONE	$ 1,242.19
	1478	**$ 35,742.76**		**$ 2,305.41**			**$ 27,436.22**

Monthly Rates:

Single:	$ 17.34
Couple:	$ 30.14
Family:	$ 45.56

Delta Dental of PR, Inc.
Current and History Files, dates 09/01/24 to 08/31/25, Cust = 0924 To 0924
Cash Receipts Detail Report by Customer
Cash Receipts Report

Inv No	Sls	Cust #	Company	Reference	Date Paid	Batch	Payment	Discount
6229529		0924	TRANS OCEANIC LIFE	TRANS	09/25/24	001	2158.32	0.00
6229548		0924	TRANS OCEANIC LIFE	TRANS	09/25/24	001	870.24	0.00
6229553		0924	TRANS-OCEANIC LIFE INS.	TRANS	09/25/24	001	70.95	0.00
_RECEIPT	CL0	0924	TRANS OCEANIC LIFE	TRANS	10/01/24	001	17.34	0.00
6245089		0924	TRANS OCEANIC LIFE	TRANS	10/17/24	001	2253.86	0.00
6245557		0924	TRANS OCEANIC LIFE	TRANS	10/17/24	001	709.76	0.00
6245730		0924	TRANS-OCEANIC LIFE INS.	TRANS	10/17/24	001	70.95	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	10/30/24	001	17.34	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	10/30/24	001	17.34	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	10/30/24	001	17.34	0.00
6285454		0924	TRANS OCEANIC LIFE	TRANS	11/02/24	001	17.34	0.00
6284215		0924	TRANS OCEANIC LIFE	TRANS	11/15/24	001	2364.36	0.00
6284610		0924	TRANS OCEANIC LIFE	TRANS	11/15/24	001	790.00	0.00
6284722		0924	TRANS-OCEANIC LIFE INS.	TRANS	11/15/24	001	70.95	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	11/27/24	001	17.34	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	11/27/24	001	17.34	0.00
6323630		0924	TRANS OCEANIC LIFE	TRANS	12/18/24	001	2139.76	0.00
6324014		0924	TRANS OCEANIC LIFE	TRANS	12/18/24	001	790.00	0.00
6324125		0924	TRANS-OCEANIC LIFE INS.	TRANS	12/18/24	001	70.95	0.00
6324821		0924	TRANS OCEANIC LIFE	TRANS	12/31/24	001	17.34	0.00
6365898		0924	TRANS OCEANIC LIFE	TRANS	01/13/25	001	2027.46	0.00
6366266		0924	TRANS OCEANIC LIFE	TRANS	01/13/25	001	790.00	0.00
6366376		0924	TRANS-OCEANIC LIFE INS.	TRANS	01/13/25	001	70.95	0.00
6367075		0924	TRANS OCEANIC LIFE	TRANS	01/31/25	001	17.34	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	01/31/25	001	17.34	0.00
6324844		0924	TRANS OCEANIC LIFE	TRANS	01/31/25	001	17.34	0.00
6404583		0924	TRANS OCEANIC LIFE	TRANS	02/10/25	001	2102.58	0.00
6404967		0924	TRANS OCEANIC LIFE	TRANS	02/10/25	001	790.00	0.00
6405082		0924	TRANS-OCEANIC LIFE INS.	TRANS	02/10/25	001	70.95	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	03/10/25	001	17.34	0.00
6444414		0924	TRANS OCEANIC LIFE	TRANS	03/17/25	001	1950.24	0.00
6444786		0924	TRANS OCEANIC LIFE	TRANS	03/17/25	001	790.00	0.00
6444898		0924	TRANS-OCEANIC LIFE INS.	TRANS	03/17/25	001	70.95	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	03/31/25	001	17.34	0.00
6484259		0924	TRANS OCEANIC LIFE	TRANS	04/22/25	001	2151.86	0.00
6484646		0924	TRANS OCEANIC LIFE	TRANS	04/22/25	001	790.00	0.00
6484760		0924	TRANS-OCEANIC LIFE INS.	TRANS	04/22/25	001	70.95	0.00
6527318		0924	TRANS OCEANIC LIFE	TRANS	05/09/25	001	2126.26	0.00
6527707		0924	TRANS OCEANIC LIFE	TRANS	05/09/25	001	699.58	0.00
6527826		0924	TRANS-OCEANIC LIFE INS.	TRANS	05/09/25	001	70.95	0.00
6528544		0924	TRANS OCEANIC LIFE	TRANS	05/30/25	001	17.34	0.00
6568366		0924	TRANS OCEANIC LIFE	TRANS	06/09/25	001	17.34	0.00

Delta Dental of PR, Inc.
Current and History Files, dates 09/01/24 to 08/31/25, Cust = 0924 To 0924
Cash Receipts Detail Report by Customer
Cash Receipts Report

Inv No	Sls	Cust #	Company	Reference	Date Paid	Batch	Payment	Discount
6567158		0924	TRANS OCEANIC LIFE	RTRANS	06/16/25	001	-2017.68	0.00
6567547		0924	TRANS OCEANIC LIFE	RTRANS	06/16/25	001	-759.86	0.00
6567663		0924	TRANS-OCEANIC LIFE INS.	RTRANS	06/16/25	001	-70.95	0.00
6567158		0924	TRANS OCEANIC LIFE	TRANS	06/16/25	001	2017.68	0.00
6567547		0924	TRANS OCEANIC LIFE	TRANS	06/16/25	001	759.86	0.00
6567663		0924	TRANS-OCEANIC LIFE INS.	TRANS	06/16/25	001	70.95	0.00
6567158		0924	TRANS OCEANIC LIFE	TRANS	06/17/25	001	2017.68	0.00
6567547		0924	TRANS OCEANIC LIFE	TRANS	06/17/25	001	759.86	0.00
6567663		0924	TRANS-OCEANIC LIFE INS.	TRANS	06/17/25	001	70.95	0.00
6609928		0924	TRANS OCEANIC LIFE	RTRANS	07/21/25	001	-2015.06	0.00
6610309		0924	TRANS OCEANIC LIFE	RTRANS	07/21/25	001	-713.60	0.00
6610423		0924	TRANS-OCEANIC LIFE INS.	RTRANS	07/21/25	001	-70.95	0.00
6609928		0924	TRANS OCEANIC LIFE	TRANS	07/21/25	001	2015.06	0.00
6610309		0924	TRANS OCEANIC LIFE	TRANS	07/21/25	001	713.60	0.00
6610423		0924	TRANS-OCEANIC LIFE INS.	TRANS	07/21/25	001	70.95	0.00
6609928		0924	TRANS OCEANIC LIFE	TRANS	07/21/25	001	2060.62	0.00
6610309		0924	TRANS OCEANIC LIFE	TRANS	07/21/25	001	668.04	0.00
6610423		0924	TRANS-OCEANIC LIFE INS.	TRANS	07/21/25	001	70.95	0.00
6611144		0924	TRANS OCEANIC LIFE	TRANS	07/30/25	001	17.34	0.00
6649641		0924	TRANS OCEANIC LIFE	TRANS	08/07/25	001	2142.78	0.00
6650035		0924	TRANS OCEANIC LIFE	TRANS	08/07/25	001	653.32	0.00
6650154		0924	TRANS-OCEANIC LIFE INS.	TRANS	08/07/25	001	70.95	0.00
_RECEIPT	SAI0	0924	TRANS OCEANIC LIFE	TRANS	08/22/25	001	17.34	0.00
					Total:		35742.76	0.00

DELTA DENTAL

www.deltadentalpr.com

RENEWAL CERTIFICATE

DATE: June 18, 2024

POLICY NO.: 80924 (all locations)

CLIENT NAME & ADDRESS: TRANS OCEANIC LIFE INSURANCE
PO BOX 363467
SAN JUAN, PUERTO RICO 00936-3467

RENEWAL PERIOD: FROM: September 1st, 2024 TO: August 31st, 2026

In consideration of the payment of the premiums, it is agreed that the policy above designated, is renewed by Delta Dental, for the period stated, subject to its terms, except as otherwise specified herein.

(Guaranteed for two (2) years)

RENEWAL RATES:	NOT CHANGE Locs. 0001, 0002, 9991, 9992	Local 0003 (Open Access)
Individual	$17.34	$29.56
Couple	$30.14	$59.13
Family	$45.56	$70.95

CHANGE IN BENEFITS AND/OR CO-PAYMENTS, (IF ANY):	NOT CHANGE
Coverage A: Diagnostic and Preventive Services	100%
Coverage B: Regular Restorative Services	80%
Coverage C[1]: Special Restorative Services	50%
Coverage C[2]: Prosthesis (Removable and Fixed)	50%
Coverage D: Orthodontic	50%

MAXIMUM:	NOT CHANGE
Per person per Calendar year.	$1,000
Lifetime maximum in Orthodontic, for adults and children under 26 years old.	$1,000

This Renewal Certificate forms part of the dental insurance policy, which above number is indicated, and to which must be permanently attached.

ACCEPTED

Elsa Figueroa / Gte HR
Name & Title

Signature

DELTA DENTAL OF PUERTO RICO, INC.

DELTA DENTAL OF P.R. INC. 2002 CORPORATE SEAL SAN JUAN, PR

Countersignature of Authorized Person

Delta Dental of Puerto Rico, Inc.
14 #2 Street, Ste. 200
Guaynabo, Puerto Rico 00968-1735

Phone: 939-205-3300
Fax: 787-749-2600