MAPFRE Sigorta

INFORMATION FORM FOR THE COMPLEMENTARY HEALTH INSURANCE

This document consists of three copies and has been prepared for the purpose of providing Policy Owners and other individuals covered by the policy with information on their rights, obligations, the subject of the contract, its execution and other significant changes and developments as per the Regulation on the Disclosure Obligation of Insurance Companies published on 28.10.2007.

A - SUBJECT AND SCOPE OF COVERAGE

This insurance guarantees to pay additional fees that may arise (the part which has not been covered by the Social Security Institution) while the persons with General Health Insurance and the ones they are obliged look after, who are included in the coverage by Social Security Institution are receiving healthcare services from the healthcare providers contracted/having a protocol with Social Security Institution as determined by MAPFRE SİGORTA A.Ş. in accordance with Health Insurance General Conditions and these special conditions. This coverage is valid for all cases covered by the Social Security Institution, except for the cases specified under Article 2 of Special Conditions.

According to the provisions of Social Insurances and General Health Insurance Law, the contributions that beneficiaries of healthcare services are obliged to pay shall not be covered by this policy. Coverage stated in the policy is only applicable for the persons whose names are included in the policy and they do not cover any other person.

B - POLICY PREMIUM ACCOUNT

The health plan and coverage chosen based on the Insurer's Risk Acceptance Regulation. Considering age and gender of the Policyholder, inflation in health industry and damage/premium ratio of the portfolio, premium tariffs are specified by the company and announced to sales channels. Calculation is made according to this tariff

Policy premium is calculated based on the age in the insurance commencement date (calculation of difference between commencement date and date of birth as day/month/year). The Insurer can apply a discount and/or additional premium for policies meeting the following conditions.

Policy payment schedule can be implemented as a down payment, or with installments. No discount is applied for down payment.

In the case that the person who is not actively employed subject to Social Security Institution premium on the commencement of the policy is Policyholder with employee premium and this case is determined in the policy period, the required premium difference is accrued with an addendum.

The No-Claim Discount;

(NCD) system consists of an entry level and a total of 7 discount levels, making a total of 8 levels. New policyholders and policyholders who transfer their policy start at the entry level (1st level) in this application. Based on the **"Claims"/"Health Net Premium" (C/H) ratio** and the policy level for the current policy period, the level for the next year's renewal policy is determined. For policyholders who have entered the policy on a day basis and have a duration of less than 6 months, the starting level will be 1 The level of the renewal policy is determined based on the current policy period level and the **"Claims"/"Health Net Premium" (C/H) ratio**. The renewal policy...

- If the Claims/Premium ratio is less than 25%, the policy will move up one level.
- If the Claims/Premium ratio is between 25.01% (inclusive) and 70% (inclusive), the policy will remain at the same level.
- If the Claims/Premium ratio is between 70.01% (inclusive) and 150% (inclusive), the policy will move down one level.
- If the Claims/Premium ratio is between 150.01% (inclusive) and 350% (inclusive), the policy will move down two levels.
- If the Claims/Premium ratio is 350.01% or higher, the policy will be renewed at three levels lower.

The discount rate for each tier is as follows:

DI SCOUNT	1	2	3	4	5	6	7	8
EACH TI ER (%)	0	15	25	35	40	50	55	60

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Policyholders who have changed their product are not subject to the entitled discount or additional premium rate of the current product, but to the no claims discount and additional premium application of the new purchased product

C - GENERAL INFORMATION AND WARNINGS

1. The Policy Owner/Policyholder must submit their insurance request after filling out the Application Form fully and accurately. Application forms must be filled out fully and bear wet signature. Applicants are also obliged to provide details of any circumstances known to them that may have an impact on the likelihood of the risk materializing even if there are no specific questions in the Application Form to that end. Any change in circumstances following the making of the contract should be immediately reported to the Insurer. Please refrain from providing any missing or inaccurate information as doing so may result in your right to indemnity being revoked or generate negative consequences in terms of your policy. Fields left blank in the Application Form will be assumed to have been answered as NO.

2. The Insurer may request the applicant to have a medical examination to assess the health status of the Policyholder. As per the Regulation on Risk Acceptance, the Company reserves the right to refuse or offer a conditional acceptance of the application depending on the applicant's health status. If the application is denied the Application and Information Form becomes void.

3. Policy cancellations are processed upon the written application of the policy owner. The information form attached to the Application Form loses its validity as of the start date of the supplementary document

4. Provisions of the Code of Obligations shall apply in the event of a default in the payment of insurance premiums in accordance with Article 8 of the General Conditions of Health Insurance.

5. Insurance premiums are tax deductible. Please consult your Insurer regarding this matter.

6. If any of the Policyholders covered by the policy are engaged in an attempt that conflicts with the general terms and application principles of policy and which intentionally aims at getting benefits, the policy of all the Policyholders shall be immediately terminated.

7. Insurance company is entitled to request information and records related to the health background of the Policyholder, from all doctors who have treated the Policyholder, from health entities and third persons, before and after the insurance period. If the Policyholder will not allow this in good faith, the insurer can reject to pay indemnity, or can terminate the agreement.

8. At renewal times, the insurer specifies coverage, limits, and premiums associated with coverage reasonably, and is entitled to change the policy special conditions. This change will be effective as of the renewal date for each Policyholder.

9. For more information on the insurance please carefully read the Fark Yok (No Extra Fee) Special Conditions and the Health Insurance General Conditions attached to the policy.

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10. Policies start, unless otherwise agreed, at 12:00 on the policy start date and end at 12:00 on the policy end date, and when the risk materializes in any case.

11. The Policy Owner is obliged to inform the Policyholder to reply all the questions asked completely and accurately, and advise all conditions that may require the company not to execute the agreement, or to execute the agreement with more severe conditions. If the company requires doctor's opinion or some tests to be carried out at the application stage or throughout the insurance term, expenses of these will be paid by the Policy Owner/Policyholder.

12. In order for us to reach you more easily in case of any changes in your information such as identity, address, phone number, etc. found on our system, please contact info@mapfre.com.tr or the fax number 0212 334 90 19.

13. If the contract of one or several In-Network Health Care Providers written in the policy with the Social Security Institution expires within the policy term and no other provider in-network with the Social Security Institution and written in the policy remains in the region where the Policyholder resides, this policy is annulled automatically. The insurer shall be entitled to receive premiums depending on the time elapsed between the commencement date of the terminated policy to the cancellation date

D - EXCEPTIONS

Please refer to exceptions in the General Conditions for Health Insurance and Special Conditions for Fark Yok (No Extra Fee) Health Insurance to find out more about conditions that are not covered by the policy.

E - WAITING PERIOD

İşbu poliçede Yatarak Tedaviler kapsamında (Kırmızı Alan durumları hariç olmak üzere) tüm işlemler ve ayakta veya yatarak olmasına bakılmaksızın tüm fizik tedavi ve rehabilitasyon ile ilgili giderler için teminatın alındığı tarih itibarıyla ilk 3 ay bekleme süresi bulunmaktadır.This policy includes an initial waiting period of 3 months as of the date of purchase of the coverage for all procedures within the scope of Inpatient Treatment (except for the Red Zone cases) and all physical therapy and rehabilitation expenses, regardless of such services are outpatient or inpatient services.

F - LIFETIME RENEWAL GUARANTEE

"Lifetime Renewal Guarantee" is given within the conditions to be determined as a result of risk analysis assessment to be made for Policyholders having Health insurance policy, on condition that the Policyholders continues to the insurance with Fark Yok (No Extra Fee) Health Insurance product for 3 years in MAPFRE SİGORTA A.Ş. without interruption and his/her average Damage / Premium ratio is under 80% for the last three years.

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For the policies to be transferred from another insurance company to MAPFRE SİGORTA A.Ş. Fark Yok (No Extra Fee) Health Insurance, risk analysis shall be made to Policyholders and practices such as limit, share, additional premium, exemption shall be valid, whether there is a renewal guarantee or not. The renewal right acquired with the previous company shall be subject to a review by MAPFRE SİGORTA A.Ş. whereby the Policyholder may be allowed, following a risk assessment, to retain his/her renewal right subject to the special terms of the Insurer.

In the case that it is transferred from other products of our company to the Fark Yok (No Extra Fee) Health Insurance product, the right of Lifetime Renewal Guarantee shall be reserved. However, in the case that it is requested to be transferred from Fark Yok (No Extra Fee) Health Insurance product to a different product, risk analysis is made by the Insurer once again. The Insurer may require medical examinations to assess the health status of the Policyholder applying for a 'Lifetime Renewal Guarantee'. The Insurer may, in accordance with the current risk acceptance regulations, reject or conditionally accept the application (limits, additional premiums, contributions, waiting period etc.) or offer an unconditional "Lifelong Renewal Guarantee" according to the applicant's health status. The Policyholder may apply to the Insurer for the purpose of extending the scope of the coverage in the Insurance Policy and/or adding a different product, network, coverage during policy renewal even if a Lifetime Renewal Guarantee is possessed. In such a case, the Policyholder's existing right to Lifelong Renewal Guarantee shall be reserved.

The Renewal Guarantee is personal, and cannot be passed on to third persons. The phrase "Lifelong Renewal Guarantee has been granted" provided to the Policyholder by the Insurer is stated in the certificate of each Policyholder.

Insurer does not have right to make risk analysis assessment and apply a new additional condition such as additional premium, exception, limit due to diseases occurring after the date that renewal guarantee is given for a Policyholder who has "Lifetime Renewal Guarantee" except the situations stated in the article 6 and 7 of Health Insurance General Conditions. The Insurer may decide to review his/her decision to issue a "Lifelong Renewal Guarantee" if the Policyholder wishes to expand his/her coverage during this period. The health policy offered by the Insurer to their Policyholders, to whom they have undertaken to provide a renewal guarantee, is subject to the Special Conditions on the date that the policy was granted the renewal guarantee right. The Insurer has the right to make changes to the group of in-network providers

Nevertheless, the renewal guarantee for Policyholders insured for the first time before 23.04.2014, entitled or not yet entitled to a renewal guarantee shall be continued to be provided under the phrase "Renewal Guarantee Provided Without a New Risk Assessment". Excepting cases outlined in Article 6 and 7 of the Health Insurance General Conditions, the Insurer may not perform a risk analysis or add additional terms such as additional premiums, exceptions, limits and contribution rates due to illnesses arising after the issuance of the Lifelong Renewal Guarantee. Such Policyholders shall be charged the additional premiums mentioned in the information form and special terms depending on their claim/premium ratio. The criteria for the assessment of the renewal guarantee, which are explained in the relevant article shall be applied in the same way for these Policyholders.

G - CANCELLATIONS

For the requests approved by the Insurer, the Insurer is entitled to collect premium on days basis, from the start date to the cancellation date. The amount to be returned to the Policy Owner/Policyholder due to cancellation is calculated based on days by taking paid indemnity into consideration. If the indemnity payments made to the Policyholder do not exceed the premium amount earned by the Insurer, the Insurer deducts the paid-in premiums due to them and refunds the remaining sum to the Policyholder. If indemnities paid to the Policyholder exceed the premium amount the Insurer is entitled to, but do not exceed the premium amount that the Insurer collects,

Insurer deducts the indemnity amount from collected premium amount and returns the remaining premium to the Policyholder. If the indemnity amount paid to the Policyholder exceeds both premium amount that the Insurer is entitled to have and the premiums paid by the Policyholder, cancellation is done without refunding the premiums. When the risk occurs, the part of indemnity amount that the Insurer is obliged to pay becomes due, even if the premiums are undue.

In the requests for reactivating policies after policy cancellation, Application Form is filled out again and risk reassessment is made.

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If the Insurer catches the Policyholder/Policy Owner acting in bad faith (making persons not covered by the policy benefit from the policy's warranties, misrepresentation of health expenditures as costs incurred by other Policyholders, discovery of medical conditions known to the applicant before the insurance start date but deliberately not reported etc.). The Insurer has the right to receive health expenses that he/she has paid with their interests and costs and/or cancel the policy without premium return.

If the contract of one or several In-Network Health Care Providers written in the policy with the Social Security Institution expires within the policy term and no other provider in-network with the Social Security Institution and written in the policy remains in the region where Policyholder resides, this policy is annulled automatically. However, if the contract of the health institution with the Social Security Institution is terminated for any reason whatsoever while the Policyholder's required inpatient treatment is ongoing, the expenses to be incurred until the completion of the treatment shall be within the scope of the policy coverage. The insurer shall be entitled to receive premiums depending on the time elapsed between the commencement date of the terminated policy to the cancellation date. In the event of the death of the Policyholder, the policy shall be null and void. Where the Policyholder and Policy Owner are different in the policy and the Policy Owner becomes deceased, the Policyholders may continue the policy by changing the Policy Owner. In this case, the policy continues by changing the Policy Owner. In the cases where the approval of legal successors is not received, the procedures are applied in line with the cancellation criteria stated above and the premium return is made to legal successors, if any.

H - CONTRACT RENEWAL

The Policyholder may apply to the Insurer for a new contract (policy) 30 days after the expiry date of the existing policy at the latest. If 30 days or more have passed since the renewal date, a new Application Form shall be prepared for the Policyholder as if he/she is a new Policyholder, and he/she shall be included in the insurance like a new Policyholder.

During the policy renewal period, the Insurer reserves the right to apply additional premiums or discounts according to the Damage/Premium rate for the Policyholder that has not received a Lifetime Renewal Guarantee, not renew the policy according to damage premium ratio and/or risk acceptance criteria, and make conditional acceptance practices such as exemption, share, limit, additional premium.

I - SAGMER (INSURANCE SURVEILLANCE CENTER) NOTIFICATION

By signing the relevant documents, persons covered or to be covered by the policy consent to their health information, insurance records and other details being taken from the Insurance Information and Surveillance Center (SBGM), Social Security Institution, Ministry of Health, health institutions and organizations and insurance companies and the concerned data and records held by the company to being shared with the Insurance Information and Surveillance Center, insurance companies and authorities authorized by the relevant legislation, for accurate risk assessment or to help finalize indemnity claims.

J - INDEMNITY PAYMENT

Expenses that may be incurred by the Policyholder while receiving health services from the In-Network Provider and/or Providers included in the Policy shall be paid directly to the in-network provider after the authorization to be provided to the provider following the confirmation that the expenses are covered by the policy coverage. Invoices and documents related to the authorization shall be sent to the Insurer by the In-Network Provider. In case of unauthorized transactions, the invoices for the Policyholder's own expenses shall not be considered to be within the scope of the Policy. All expenses out of the policy coverage shall be paid by the Policyholder.

K - OTHER INFORMATION

The insurer is not a member of the Insurance System of Arbitration.

L - COMPLAINTS AND REQUESTS FOR INFORMATION

1- Please contact us on the following numbers or write to us at the following address for more details on your insurance policy, including its negotiation and drawing up, any technical issues, insurance transactions performed or to be performed, the warranties offered by the contract and how the policy works, as well as any information requests and complaints. The insurer must respond to requests within 15 business days following receipt of the claim

2- Contact our Customer Service Center on 0850 755 0 755 if you still have not received your policy agreement or rejection letter within 30 days from the date of your application.