MAPFRE Sigorta

INFORMATION FORM FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

Please ensure that all information in this form is completed in full.

Prepared in three counterparts, this form has been drawn up in accordance with the Regulation on Information Requirements in Insurance Contracts published on 28/10/2007, for the purpose of providing the Policyholder and other beneficiaries of the insurance with general information, both during the negotiation of the insurance contract to be concluded and throughout the term of the insurance, regarding their rights and obligations, the subject matter of the contract, its functioning, and certain material changes and developments.

A - COVERAGES

1. The Insured(s) shall be covered, in accordance with the Turkish Commercial Code (TCC), General Provisions, General Terms and Conditions of Health Insurance, and Special Terms and Conditions, for expenses incurred for diagnosis and treatment resulting from any illness and/or accident occurring within the policy/endorsement commencement and expiry dates, within the scope of the coverage, limits, co-payment rates, and practices specified in the policy/endorsement.

2. In addition to the general terms and conditions of insurance, the Parties have the right to agree upon special terms, provided that they are not contrary to law, public order, or morality, and are not to the detriment of the Insured. Your health insurance policy may vary depending on the product and coverages selected. All coverages relating to the products are set out below.

a. Outpatient Treatment Coverages

TSS Doctor Consultation (Supplementary Health Insurance)	TSS Laboratory	TSS Modern Diagnosis	TSS Radiology
TSS Physiotherapy			

b.Inpatient Treatment Coverages

Surgery/Hospitalization	Chemotherapy	Intensive Care	Hospital
Surgeon’s Fee	Dialysis	Radiotherapy	Room & Companion
Post-Hospitalization Physiotherapy and Rehabilitation	Emergency Diagnosis	Minor Intervention	

c. Other Coverages

Home Care	Maternity	Prosthesis	Overseas Inpatient
Control PSA/Mammography	Check Up	Auxiliary Medical Equipment	
Air/Ground Ambulance	Supplementary Outpatient Treatment		

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Coverage and waiting periods may vary depending on the product and plan selected. In addition to the provisions set forth in the general and special terms of the policy, the insurance company may, based on the statements made at the time of the policy application and in accordance with its own risk acceptance principles, exclude certain conditions, illnesses, or accidents from coverage by way of special exclusions on a policy basis. For optional additional coverages, please consult your customer representative. Kindly review and check the coverages specified in the quotation and policy provided to you.

B - POLICY PREMIUM CALCULATION

In accordance with the Insurer's Risk Acceptance Guidelines, the premiums of the prospective Insured are calculated based on the tariff sales premiums determined by the Company and announced through all sales channels, taking into consideration the selected plan, coverages, the Insured's age and gender, medical inflation, and the loss/premium ratio of the relevant age group within the portfolio. In the event that, after the inception date of the insurance, the addition of a spouse or child under the family coverage or a request by the Insured for a change of plan is made, such requests shall be processed on the basis of the premiums in force on the date of the request, without prejudice to the Insurer's right to reject the request. The premiums, discounts, and due dates applicable to the Insured are stated on the front page of the policy. The policy premium is calculated based on the age of the Insured on the Policy Commencement Date (calculated as the difference between the commencement date and the date of birth in day/month/year format).

DISCOUNTS AND ADDITIONAL PREMIUMS

MAPFRE Sigorta A.Ş. issues the Insurance Policy by calculating the predetermined discount and additional premium rates for policies that meet the conditions specified below.

1 - NO-CLAIM DISCOUNT

The No-Claim Discount scheme consists of an entry level and 7 discount levels, making a total of 8 levels. Policyholders who obtain a new policy or transfer their policy start from the entry level (Level 1) under this scheme. The level of the renewal policy for the following year is determined by taking into account the Policyholder's current policy period level and the **"Claim/Net Health Premium" (C/P) Ratio**.
For Policyholders whose insurance duration in the previous year's policy, calculated on a daily basis, is less than 6 months, the starting level shall be Level 1.
The level of the renewal policy is determined by taking into account the Policyholder's current policy period level and the **"Claim/Net Health Premium" (C/P) Ratio**:

- If the Claim/Premium ratio is less than 25%, one level higher.
- If the Claim/Premium ratio is between 25.01% (inclusive) and 70% (inclusive), the same level.
- If the Claim/Premium ratio is between 70.01% (inclusive) and 150% (inclusive), one level lower.
- If the Claim/Premium ratio is between 150.01% (inclusive) and 350% (inclusive), two levels lower.
- If the Claim/Premium ratio is 350.01% (inclusive) and above, three levels lower.

The discount rate for each level is as follows:

LEVEL	1	2	3	4	5	6	7	8
DISCOUNT RATES (%)	0	15	25	30	35	40	45	50

2 - LOYALTY DISCOUNT

The Loyalty Discount shall be applied per Insured in the renewal of uninterrupted policies, at rates varying according to the policy years. The Loyalty Discount is not applicable when transferring from a group health policy to an individual health policy.

3 - FAMILY DISCOUNT

A Family Discount is applied if the individual health policy covers at least 2 or more persons consisting of parents and children. The Family Discount applies even if different plans or products are purchased within the family.

4 - REGIONAL (PROVINCE) DISCOUNT

The Regional Discount is automatically granted by the system based on the province of residence of the individual.

5 - FIRST INSURANCE DISCOUNT

The First Insurance Discount is applied to Insureds who are included for the first time under an individual health insurance policy and are subject to a waiting period.

6 - RISK SURCHARGE

Additional premiums applied by the insurance company to the Insured, based on the statements provided in the Application Form and/or documents and information obtained, following an evaluation of the Insured's risk. The Risk Surcharge may apply to all coverages and/or certain coverages. The maximum applicable Risk Surcharge is 200%. During the risk assessment process, the approval of the Policyholder and/or the Insured must be obtained for the requested risk surcharge.

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C - GENERAL INFORMATION AND WARNINGS

1. Health insurance covers infants older than 14 days and individuals under the age of 64 (inclusive).

2. The Policyholder/Insured must submit their insurance applications by completing the Application Form fully and accurately, and such Application Forms must bear wet-ink signatures. Furthermore, even if not expressly asked in the Application Form, you are obliged to declare, at the time of application, any other circumstances known to you that may influence the assessment of the risk subject to the contract.
It is mandatory to notify the Insurer within the prescribed period of any changes occurring after the conclusion of the contract. Please note that providing incorrect or incomplete information may nullify your right to indemnity or result in adverse consequences; therefore, refrain from giving incomplete or false information to the Insurer at any stage of the contract. Any unanswered questions in the Application Form shall be processed as “NO.”

3. The Insurer may request medical examinations in order to evaluate the Insured’s health risk. In line with the health condition and/or the Risk Acceptance Guidelines, the Company reserves the right to reject the application or to accept it conditionally. In the event of rejection, the Application and Information Form shall cease to be valid.

4. Policy cancellation procedures are processed on the basis of the written declaration of the Policyholder. Upon completion of the relevant procedure, the information form attached to the Application Form shall cease to be valid as of the inception date of the additional document.

5. Pursuant to Article 8 of the General Terms and Conditions of Health Insurance, in the event of default in the payment of premiums under health insurance, the provisions of the Code of Obligations shall apply.

6. In order to avoid future disputes, please do not forget to obtain a receipt if you pay the premium down payment in cash.

7. Premiums paid for insurance may be tax-deductible. Please consult your Insurer in this regard.

8. Following the conclusion of the contract, any changes made without the consent of the insurance company that may affect the risk must be notified to the insurance company within eight days, in accordance with Article 7 of the General Terms and Conditions of Health Insurance.

9. If any of the Insureds under an individual policy engage in an act contrary to the general terms and conditions of the policy and the rules of application, with the intention of obtaining unjust benefit, the policies of all Insureds under the policy shall be immediately terminated. Within the ongoing policy period, based on the health condition of the Insured as determined (including cases of incomplete and/or incorrect declarations or lack of disclosure), the Insurer may conduct a second risk analysis and establish a new conditional acceptance (exclusion, additional premium, limit, standard, etc.) in relation to the determined situation.

10. If the Insurer requests a medical examination and additional tests in order to determine the Insured’s state of health; the expenses related to such procedures shall be borne by the Insurer if the Insured grants access to his/her past medical records, and by the Policyholder/Insured if the Insured does not grant access to his/her past medical records.

11. For more detailed information regarding the insurance, please carefully read the Special and General Terms and Conditions of Health Insurance.

12. The exclusions, coverages, limits, co-payment rates, plan information, etc. relating to the Insured are specified in the policy.

13. Unless otherwise agreed, the insurance shall commence at 12:00 noon Turkey time on the date stated in the policy as the inception date and shall expire at 12:00 noon on the date stated as the expiry date, and in any case upon the occurrence of the insured risk.

14. Provided that all required information and documents are fully submitted to the Insurer, the Insurer shall complete the necessary assessments and finalize the indemnity procedures within a maximum of 10 days.

15. In the event that the contact information provided in the Application Form is incomplete or incorrect, the insurance company shall not be held responsible for failure to provide notification. In order for us to contact you more easily, please inform us of any changes to your identity, address, telephone, etc. details available in our system, by e-mail to musterihizmetleri@mapfre.com.tr or by fax to +90 212 334 62 60.

16. You may access all information regarding your policy through the “Insured Online” system available under the “Online Transactions” section on our website at www.mapfre.com.tr.

17. MAPFRE Sigorta A.Ş. reserves the right to change the contracted institutions determined for the Network during the policy period or to completely remove the relevant Contracted Institution from the scope of the contracted network.

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D - EXCLUSIONS

The circumstances excluded from coverage as set forth in Article 2 of the General Terms and Conditions of Health Insurance, together with the situations listed below, are excluded from all coverages under this Policy. However, the circumstances listed under Articles 39 to 49 shall be considered within the scope of the Policy only for outpatient treatment expenses, provided that the Insured has acquired the right to the Lifetime Renewal Guarantee prior to 01.10.2023, such expenses are covered by the Social Security Institution (SGK), and there is no special exclusion regarding this matter in the policy.

1. The illnesses specified in this clause are excluded from coverage; however, the exclusions shall not apply if the Insured has continuously maintained individual insurance with our Company for at least 3 years and has acquired the Lifetime Renewal Guarantee, or if the Insured is insured as a MAPFRE Baby:

a. Congenital and genetic diseases diagnosed after the Policy Commencement Date, even if manifested at a later age; and, unless otherwise agreed in the contract, expenses relating to premature infants (except in cases where the Neonatal Incubator Additional Coverage has been purchased and the relevant coverage conditions are met), even if the infant is insured from birth.

b. Expenses related to examinations and treatments for pes planus and hallux valgus/rigidus.

c. Treatments for dementia arising from old age, as well as Alzheimer's disease, Parkinson's disease, and epilepsy.

d. Operations performed for nasal septum and concha.

• Operations for nasal septum and concha shall be valid only in the Contracted Healthcare Institutions specifically designated by the Insurer under the title of the ENT Network and listed on the MAPFRE Sigorta website, regardless of the type of Contracted Healthcare Institution stated in the Policy. In the event that the Insured's treatment is performed by a Non-Contracted Physician at a Contracted Healthcare Institution included in the ENT Network, the physician's fee shall be payable up to the maximum amount specified in the HUV Tariff (HUV*1).
However, if the Insured has continuously maintained individual insurance with our Company for at least 5 years and has acquired the Lifetime Renewal Guarantee, these operations shall be valid in all Contracted Healthcare Institutions covered under the Policy. In such cases, if the treatment is performed by a Non-Contracted Physician at a Contracted Healthcare Institution, the physician's fee shall be calculated in accordance with the Non-Contracted Institution limits and co-payment rates specified under Surgeon and Physician Expenses.

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2.If the Insured has continuously maintained individual insurance with our Company for at least 5 years and has acquired the Lifetime Renewal Guarantee, or if the Insured is covered as a MAPFRE Baby, treatments relating to strabismus, otosclerosis, keratoconus, and ptosis that occur after the initial enrollment date of the policy shall not be considered exclusions. Such treatments shall be valid only in Contracted Healthcare Institutions within the scope of the C network, regardless of the network type stated in the Insured's policy. For Insureds who have not completed 5 years under their individual policy with our Company and who have not acquired the Lifetime Renewal Guarantee, these treatments are excluded from coverage. The Contracted Healthcare Institutions within the C network can be accessed through the Contracted Healthcare Institutions page on the MAPFRE Sigorta website.

3. Expenses relating to neonatal incubator care for the newborn baby of an Insured who has not completed the Maternity Waiting Period or who is covered under a plan without Maternity Coverage.

4. All medical expenses related to pre-existing conditions/diseases existing prior to the initial policy enrollment date with MAPFRE Sigorta and not disclosed, including recurrences and complications thereof (regardless of whether a diagnosis has been made and/or treatment has been provided).

5. Examinations related to the investigation of any genetic disease/condition, genetic mapping, and genetic screening.

6. All expenses related to any accident and resulting injuries arising from driving without a valid driver's license.

7. Mental illnesses and psychological disorders requiring psychiatric treatment, neuropsychiatric tests, all kinds of psychotherapy, and all related expenses.

8. Expenses arising from all hazardous sports activities, whether amateur or hobby-based, and/or other hazardous activities including but not limited to mountaineering, scuba diving, airplane and glider piloting, parachuting, paragliding, hang gliding, horseback riding, rafting, street luge, high-altitude jumping sports (such as base jumping), kiteboarding, kitesurfing, underwater sports, mountain biking, motorcycling and automobile sports, and the use of electric scooters, electric bicycles, and electric motorcycles without a license, as well as skiing, and the use of motorcycles as driver or passenger for transportation purposes, are limited to 40,000 TRY. Among these activities, only skiing and the use of motorcycles and ATVs as driver or passenger for transportation purposes, provided a valid license is held, may be included within the scope of coverage subject to additional premium, within the policy limits and coinsurance rates, unless the risk occurs.

9. Regardless of the institution where they are performed, alternative treatment methods (such as acupuncture, homeopathy, osteopathy, hypnosis, yoga, mesotherapy, aromatherapy, neural therapy, chiropractic treatments, Ayurveda, phytotherapy, functional medicine, holistic medicine, ozone therapy, spa and hydrotherapy treatments, etc.), as well as treatments performed in spas, thermal centers, sanatoriums, nursing homes, care homes, preventoriums, and rehabilitation centers.

10. All expenses related to unproven/experimental treatments and drugs or materials not approved by the U.S. Food and Drug Administration (FDA).

11. Inpatient Treatment Coverage for procedures/treatments not listed in the HUV (Medical Practices Database).

12. All procedures and related expenses (examination, tests, diagnosis, treatment, etc.) performed in aesthetic, cosmetic, laser and beauty centers, optical centers, institutions without a Ministry of Health operating license, wellness centers, traditional/complementary and alternative medicine centers, anti-aging centers, weight loss centers, sports centers, life- coaching centers, and foot health centers.

13. All procedures and related expenses performed by medical practitioners without a Ministry of Health operating license and by individuals who are not licensed physicians.

14. Expenses related to nasal valve surgery.

15. Expenses incurred for obtaining medical board or doctor's reports required prior to sports, marriage, or employment.

16. Invoices issued by the Insured's first-degree relatives.

17. Expenses incurred for the removal of the Insured's special exclusions.

18. Expenses related to inpatient treatments without medical indication, as determined by reports received from hospitals and evaluated by the MAPFRE Sigorta Medical Procedures Center, as well as diagnostic and treatment expenses that are not related to a specific complaint and/or illness.

19. All diagnostic and treatment expenses related to uvuloplasty, snoring, and sleep apnea. (All expenses related to uvuloplasty and sleep apnea shall be included within the scope of coverage for Insureds who have acquired the Lifetime Renewal Guarantee prior to 01.10.2023.)

20. All diagnostic and treatment expenses related to scoliosis and all spinal deformities. (Scoliosis and all spinal deformities shall be included within the scope of coverage for Insureds who acquired the Lifetime Renewal Guarantee prior to 01.10.2023.)

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21. Expenses related to cord cyst, hydrocele, and all types of hernia procedures in children under the age of 7. (As an exception, this article shall not apply to MAPFRE Babies.)

22. Expenses for medical supplies not covered under the Ancillary Medical Equipment Coverage defined in Article 3.1.13, CPAP devices, their calibration and monitoring, humidifiers used at home, externally attached devices (such as hearing aids, cochlear implants, etc.), non-medicated syringes, bandages, telephone, TV, cafeteria, administrative services, paramedical services, service charges, and any expenses related to external and supportive prostheses that cannot be evaluated under the Inpatient Treatment Coverage)

23. Expenses for elective curettage, infertility (sterility), miscarriage investigation, and all diagnostic, treatment, and complication expenses related to achieving pregnancy (such as in vitro fertilization, follicle monitoring, microinjection, tuboplasty, etc.), hysterosalpingography (HSG), spermiogram, and adhesiolysis expenses.

24. All expenses related to circumcision and phimosis, even if medically required.

25. Expenses for sclerotherapy, chemical blockade, laser, radiation, massage, stockings, etc. applied for the treatment of superficial varicose veins.

26. Expenses related to the collection and storage of cord blood and stem cells.

27. All expenses related to officially declared epidemics and epidemics initiated with malicious intent.

28. Co-payments that Insureds are obliged to pay pursuant to Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510.

29. Expenses for private nursing not approved by the MAPFRE Sigorta Medical Procedures Center (except those covered under Home Care Coverage), ambulance expenses other than Emergency Situations (as defined in Article 2 Definitions), and all expenses related to auxiliary healthcare personnel (such as physiotherapists, respiratory therapists, caregivers).

30. All expenses related to examinations, dental and gum treatments, and jaw treatments performed by dentists and oral surgeons, as well as costs of toothpaste, oral and dental care products, etc.

31. Expenses related to eyeglasses, lenses, lens solutions, all corrective lenses for refractive errors (toric, multifocal, etc.), treatment of amblyopia, treatments of refractive errors (such as myopia), and all diagnostic, examination, and treatment expenses for strabismus, except for MAPFRE Babies.

32. Rental or usage fees of any medical equipment and/or devices, except those covered under Home Care Coverage.

33. For procedures evaluated under outpatient diagnosis/treatment coverage: medical expenses incurred during periods when the General Health Insurance provided by the Social Security Institution is inactive due to reasons such as termination of employment or non-payment of insurance premiums.

34. Medical expenses evaluated under Outpatient Treatment Coverage but incurred outside Contracted Healthcare Institutions listed under the Policy.

35. All expenses exceeding the number of uses and/or coverage limits specified in the Policy.

36. Under outpatient treatments, including the Green Area application: all medicine expenses, materials and contrast agents used for examinations, material costs, and vaccination expenses.

37. Travel, per diem, second companion fees, suite room surcharges, and personal expenses.

38. All expenses incurred abroad under the scope of Outpatient Treatment Coverage.

39. All diagnostic and treatment expenses related to structural disorders, motor and mental developmental and growth disorders (such as growth and developmental delay/advance, early/late puberty, etc.).

40. Mental illnesses and psychological disorders requiring psychiatric treatment, neuropsychiatric tests, all types of psychotherapy, and all related expenses.

41. Expenses for examinations conducted for screening purposes such as coronary artery calcium scoring, coronary CT angiography, EBT (Electron Beam Tomography), as well as virtual angiography and virtual colonoscopy.

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42. Unless resulting from a judicial accident or illness (such as cancer, burns, etc.) occurring during the validity period of the Policy; plastic and reconstructive surgery, all cosmetic and aesthetic procedures (such as rhinoplasty, abdominoplasty, etc.) and related complications, treatments for telangiectasia and cutaneous hemangiomas, gynecomastia, procedures to prevent sweating and related examinations and treatments, diagnosis and treatment of acne and hair loss (except alopecia areata), all expenses related to breast reduction and augmentation surgeries, and accessory breast operations.

43. Diagnosis or treatment, surgery and complications, dietician services, weight loss and weight gain programs related to obesity, weight, and appetite disorders, and all related expenses.

44. Examination, diagnosis, treatment, and complication expenses incurred for balanced nutrition, diet-exercise programs, and physicians applying alternative and/or complementary therapies.

45. Surgery for hearing defects (except insertion of tubes, tympanoplasty, sequelae of chronic otitis, etc.), and all examinations and treatments related thereto, as well as speech and voice therapies.

46. Expenses related to varicocele, whether or not associated with infertility, except for Insureds under the age of 18.

47. All diagnostic and treatment expenses related to gender reassignment surgeries, erectile dysfunction, Peyronie's disease, penile curvature, vaginismus, sexual dysfunctions (including penile prostheses), and birth control methods (such as pills, condoms, etc.) not included under Article 3.4.3.

48. All diagnostic and treatment expenses related to syphilis, anogenital condylomas, HIV, and AIDS, regardless of the mode of transmission.

49. Expenses related to the donor in organ, tissue, and blood transplantation.

E - STANDARD WAITING PERIODS

The conditions listed below shall be excluded from all treatments during the respective waiting periods, unless arising from a judicial accident, as of the Insured's Enrollment Date. Provided that the Insurance Policy is continuously renewed under its renewal conditions and no special exclusion has been imposed by the Insurer for any of the situations listed below, the standard Waiting Periods set forth herein shall not apply to Insureds who have uninterruptedly completed the relevant waiting period, and if an additional Waiting Period has been imposed by the Insurer, such Waiting Period has also been completed, and the respective conditions shall be included in the coverage.

Conditions with a 12-Month Waiting Period for Inpatient Treatment Coverage (unless arising from a judicial accident):

1. All hernias

2. Anorectal diseases (hemorrhoids, anal fistula and fissure, anal abscess, etc.), pilonidal sinus (sacral dermoid cyst)

3. Tonsillectomy, adenoid vegetation surgery, tympanic membrane surgery and tube insertion, sinus surgery

4. Excision of all benign tumors, space-occupying lesions, nevi, polyps, and hyperplasia, etc.

5. Thyroid and parathyroid diseases

6.Diseases and operations related to the cervix, uterus, ovaries and tubes, endometriosis, cystorectocele

7. Hydrocele, spermatocele, cord cyst, and epididymal cyst.

8. Spinal and disc diseases, all types of joint disorders (knee, shoulder, etc.), trigger finger, ligament and tendon disorders, carpal tunnel, tarsal tunnel.

9. Varicose veins and venous thrombosis.

10. Urolithiasis (stone diseases of the urinary system), prostate surgeries.

11. All endoscopic and laparoscopic procedures and angiographies (except procedures performed for diagnostic purposes).

12. Cataract, glaucoma, keratoplasty.

13. Gallbladder and biliary tract diseases.

14. All chronic disease treatments and home care services for chronic diseases (hypertension, ulcer, reflux, inflammatory bowel diseases such as ulcerative colitis and Crohn's disease, COPD, asthma, diabetes, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, all rheumatic and connective tissue diseases).

15. All conditions under Maternity Coverage (routine pregnancy check-ups, normal or cesarean delivery, miscarriage and/or any complications arising therefrom, etc.).

Conditions with a 3-Month Waiting Period for Outpatient Treatment Coverage

All medical expenses related to physiotherapy and rehabilitation under the scope of Outpatient Treatment Coverage shall be subject to a 3-month waiting period as of the date the coverage is obtained.

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F - PORTABILITY PROCEDURES AND VESTED RIGHTS

Vested rights refer to the removal of waiting periods under special conditions and the rights the Insured had under the previous policy. Rights that were included in the special conditions/coverages of the Insured's previous policy but are not present in the special conditions/coverages valid for the new insurance period shall not be considered vested rights. However, rights that are included in the special conditions valid for the new period but were not present in the previous period's special conditions shall also apply to the Insured.

When renewing a policy as a transfer from another company, the Insurer reserves the right— without prejudice to the provisions of the Lifetime Renewal Guarantee, if any—to request a health declaration from the Insured, require additional examinations, request a medical check-up if deemed necessary, and impose limitations on coverages and/or conditional acceptances (such as limits, Risk Surcharge, co-payment, waiting period, etc.).

For vested rights to be granted, the Insured's initial Insurance Enrollment Date shall be taken as the basis. To preserve the initial enrollment date, the Insured must apply within 30 days from the Insurance Expiry Date.

Illnesses of the person covered by other insurance company/companies and/or illnesses determined to have existed prior to the initial date of insurance, even if such expenses were paid by the previous insurance company, shall not fall within the scope of vested rights if they were not declared in the Application Form. Such conditions are excluded from coverage.

G - LIFETIME RENEWAL GUARANTEE

Provided that the Insured has maintained uninterrupted insurance with MAPFRE Sigorta A.Ş. under the same product for 3 years and the average Claim/Premium ratio over the last three years is below 80%, a "Lifetime Renewal Guarantee" may be granted to Health Policyholders who are deemed medically eligible as a result of a risk analysis evaluation, subject to the conditions to be determined.

The Insurer may request from the Insured an application form containing up-to-date health information and, if necessary, medical reports in order to evaluate the "Lifetime Renewal Guarantee." In accordance with the prevailing risk acceptance guidelines based on the Insured's health condition, the Insurer reserves the right to reject the application, to accept it conditionally by applying restrictions (such as limit, Risk Surcharge, exclusion, co-payment, waiting period, etc.), or to grant the "Lifetime Renewal Guarantee" without any conditions.

The renewal guarantee is personal and belongs solely to the Insureds who have earned this right. The expression "Lifetime Renewal Guarantee" granted by the Insurer to the Insured shall be indicated in each Insured's policy.

For policies transferred from another insurance company to MAPFRE Sigorta A.Ş., regardless of whether there is a renewal guarantee, a risk analysis will be carried out for the Insureds, and applications such as limits, co-payments, exclusions, and Risk Surcharge may be imposed. However, any additional premium for illnesses shall not exceed 200%.

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The renewal guarantee right acquired under the previous company will be re-evaluated according to the criteria of MAPFRE Sigorta A.Ş., and within the framework of the risk analysis to be performed, the Insured's renewal guarantee right may continue under the current special conditions of the Insurer.

For an Insured who has been granted a Lifetime Renewal Guarantee, the Insurer shall not have the right, due to illnesses arising after the date the renewal guarantee is granted, to conduct a new risk analysis or impose new additional conditions such as Risk Surcharge, exclusions, limits, or co-payments, or to apply an additional premium based on the claim/premium ratio, except for the circumstances specified in Articles 6 and 7 of the General Terms and Conditions of Health Insurance.

If, during this period, the Insured wishes to expand the scope of coverage, the Insurer may conduct a new risk analysis for the newly added or modified coverage and apply conditions such as limits, co-payments, exclusions, or Risk Surcharge. The Insurer also reserves the right to reject the relevant request.

The Health Policy offered by the Insurer to the Insureds to whom it has committed the renewal guarantee shall be subject to the special conditions in force on the date the Lifetime Renewal Guarantee is acquired. For Insureds who do not have a Lifetime Renewal Guarantee, the Policy Special Conditions in force for each policy period shall apply.

H - CANCELLATIONS

If the Policyholder/Insured requests cancellation within 30 days after the policy issuance date, and provided that no insured risk has occurred, the Policy shall be cancelled retroactively as of the Policy Commencement Date and the premiums paid shall be fully refunded to the Insured.

If the indemnities paid to the Insured do not exceed the amount of premium earned by the Insurer, the Insurer shall deduct the earned premiums from the premiums collected and refund the remaining premiums to the Insured. If the indemnities paid to the Insured exceed the premiums earned by the Insurer but do not exceed the premiums collected, the Insurer shall deduct the relevant indemnity amount from the premiums collected and refund the remaining premiums to the Insured.

If the indemnities paid to the Insured exceed both the premiums earned by the Insurer and the premiums paid by the Insured, the cancellation shall be effected without any premium refund. In the event that a risk occurs, even if the premiums are not yet due, the portion corresponding to the indemnity amount payable by the Insurer shall become immediately due and payable. The Policyholder shall be in default if any of the premiums, with definite due dates and amounts stated in the policy, are not paid by the due date. In case of non-payment of premium debt on time, the provisions of Article 1434 of the Turkish Commercial Code shall apply.

If the Insurer determines that the Policyholder/Insured has acted in bad faith (such as allowing non-insured persons to benefit from insurance coverage and having healthcare expenses issued under the names of other Insureds, or failing to declare pre-existing conditions known to the Insured and/or with symptoms that began prior to the commencement date of the insurance), the Insurer shall have the right to reclaim the healthcare expenses paid and/or to cancel the policy without any premium refund.

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I - DEATH OF THE POLICYHOLDER OR THE INSURED

In the event of the Policyholder's death; if the Policyholder and the Insured(s) listed in the policy are different persons, and the Insured(s) wish to continue the policy by changing the Policyholder, the written consent of the legal heirs of the deceased Policyholder must be submitted to the Insurer. In such case, the Policyholder shall be changed and the policy shall be continued. If the consent of the legal heirs is not obtained, the policy shall be processed in accordance with the cancellation criteria specified above, and any refundable premiums, if applicable, shall be paid to the legal heirs.

In a single-person policy where the Policyholder and the Insured are the same person, the policy shall become void upon the death of the Policyholder. If requested in writing by the legal heirs of the Policyholder, the policy shall be processed in accordance with the cancellation criteria specified above, and any refundable premiums, if applicable, shall be paid to the legal heirs.

In policies covering multiple Insureds, in the event of the death of one of the Insureds, the deceased Insured shall be removed from the policy as of the date of death. Any refundable premiums, if applicable, shall be paid to the Policyholder of the policy in accordance with the cancellation criteria specified above.

İ - RENEWAL OF THE CONTRACT

This insurance shall be valid for a maximum period of 1 year. However, upon the request of the Insured/Policyholder following the expiry date of the insurance, a new policy may be issued by the Insurer under the conditions it determines. If a plan change is requested during the renewal period, a Health Declaration Form may be required.

For Insureds without a Lifetime Renewal Guarantee, the Insurer shall review the health condition and/or the claim/premium ratio during the coverage period and decide on the renewal conditions of the policy.

If the Insurer imposes conditional acceptances (such as Risk Surcharge, limit, co-payment, waiting period, etc.) for pre-existing and/or ongoing conditions in the previous period under the new contract, without prejudice to the provisions of the Lifetime Renewal Guarantee, such conditional acceptances shall remain valid as long as the policy is renewed and has not been declared void by the parties.

During renewal, the Policyholder may apply to the Insurer to expand the Scope of Coverage in the policy and/or to add different coverages. The Insurer reserves the right to request a new Application Form, to reject the application, or to accept it conditionally (Risk Surcharge, limit, co- payment, etc.). For newly added coverages, the waiting period shall recommence. Furthermore, policies shall be renewed with the current premiums, tariff, and special conditions.

The Insured may apply to the Insurer for a new contract (policy) up to 30 days prior to or within 30 days after the expiry date of the current policy.

If more than 30 days have elapsed after the renewal date, a new Application Form shall be issued for the Insured as if he/she were a new applicant, and insurance coverage shall be provided as for a new Insured. Vested rights and the previously acquired right to the Lifetime Renewal Guarantee shall no longer be valid, and a risk analysis shall be conducted for pre- existing conditions. Discounts acquired under the previous policy based on the claim/premium ratio shall also no longer apply.

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INFORMATION FORM FOR THE HEPSİ BİRLİKTE HEALTH INSURANCE

The Insurer reserves the right, until a new policy is issued, not to cover risks arising during such period, or to cover them under conditional acceptances (limit, Risk Surcharge, co-payment, waiting period, etc.) in accordance with the Risk Acceptance Guidelines, and to revoke renewal rights.

The Insured is obliged to comply with the duty of disclosure stipulated under Article 6 of the General Terms and Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code during renewal.

J - SAGMER (INSURANCE SUPERVISION CENTER) DISCLOSURE

Persons who are or will be covered under the insurance shall be deemed to have consented, by signing the relevant documents, to the collection of their health information, insurance records, and other data from the Insurance Information and Supervision Center (SBGM), the Social Security Institution, the Ministry of Health, healthcare institutions and organizations, and insurance companies for the purpose of risk assessment and settlement of claims, and to the sharing of such information and records held by the Company with the SBGM, insurance companies, and the authorities authorized under the applicable legislation.

K - CLAIM PAYMENTS

1. In order to claim rights arising from the policy, beneficiaries are obliged to submit the relevant documents to the Insurer. The documents required for claim payments may vary depending on the coverages provided under the policy and the nature of the claim. For information and documents required for claims made through non-contracted institutions, please refer to the policy annexes.

2. Information on contracted institutions, which is continuously updated, can be accessed via our website at www.mapfre.com.tr or by contacting our Customer Service Center at +90 850 755 0 755.

3. Claim payments shall be assessed in accordance with the special and general terms of the policy, any applicable additional protocols, and the coverage limits specified in your policy.

4. For applications made to our contracted institutions, your Turkish ID Number is sufficient for the provision process.

5. In the event of the occurrence of an insured risk, the obligation to make claim payments lies with the insurance company.

L - OTHER INFORMATION

The Insurer is not a member of the Arbitration System.

M - COMPLAINTS AND INFORMATION REQUESTS

1. During both the negotiation and conclusion of the insurance contract, as well as throughout the term of the contract, in addition to the verbal information provided to you regarding the characteristics of the insurance transactions to be carried out or already carried out, the insurance coverage subject to the contract, and the operation of the insurance, you may also submit any requests for information related to the insurance, as well as any complaints, to the addresses and telephone numbers listed below.

2. If your policy or your rejection letter does not reach you within 30 days from the date of application, you may contact our Customer Service Center at +90 850 755 0 755.