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INFORMATION FORM FOR THE COMPLEMENTARY SME 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.At the inception of the policy, the Insurer may, if deemed necessary, request a physician's opinion in order to determine the health status of the Insured. In line with the health condition and/or the Risk Acceptance Regulation, the Company reserves the right to reject the application or to accept it subject to certain conditions. In the event that the application is rejected, the Application and Information Form shall become null and 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. Even if the Company has obtained information regarding the Insured from the persons and institutions providing treatment to the Insured, from the Insurance Information and Monitoring Center, and from Public Institutions and Organizations, if a physician's opinion is nevertheless required, the related costs shall be borne by the Insurer. However, if the policy is established solely on the basis of the health declaration submitted by the Insured/Policyholder, any physician's opinion that may be required shall be borne by the Insured/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

Under this Policy, a 3-month waiting period shall apply, effective as of the date on which the coverage is obtained, for all procedures covered under Inpatient Treatment (except for Red Zone cases) and for all expenses related to physical therapy and rehabilitation, regardless of whether the treatment is provided on an outpatient or inpatient basis. If Maternity Coverage is purchased as an additional coverage under Individual Policies, a 9-month waiting period shall apply. If Maternity Coverage is purchased as an additional coverage under Group Agreements, a 12-month waiting period shall apply.

F - LIFETIME RENEWAL GUARANTEE

Provided that the Insured has maintained uninterrupted insurance with MAPFRE Sigorta A.Ş. under the Fark Yok Health Insurance product for 3 years, and that the Claims/Premium (C/P) ratio average for the last three years remains below 80%, a "Lifetime Renewal Guarantee" shall be granted to Insureds holding a Health Policy, subject to the conditions to be determined as a result of the risk analysis assessment to be conducted.

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For policies to be transferred from another insurance company to the MAPFRE Sigorta A.Ş. Fark Yok Health Insurance product, a risk analysis shall be conducted for the Insured regardless of whether a renewal guarantee exists. As a result of such assessment, applications such as limits, co-payment, additional premium, deductible, etc. may be imposed.

Any Renewal Guarantee right acquired at the previous insurance company shall be evaluated in accordance with the criteria of MAPFRE Sigorta A.Ş., and within the framework of the conditions to be determined, the Insured's renewal guarantee right shall be continued in accordance with the Insurer's applicable Special Conditions.

. If a transfer is made from other products within our Company to the Fark Yok Health Insurance product, the Insured's existing Lifetime Renewal Guarantee right shall be preserved. However, if the Insured requests a transfer from the Fark Yok Health Insurance product to a different product, a new risk analysis shall be conducted by the Insurer. In order to assess the health risk of the Insured applying for a Lifetime Renewal Guarantee, the Insurer may request medical examinations. Depending on the health condition and in accordance with the applicable Risk Acceptance Regulation, the Insurer reserves the right to reject the application, to accept it subject to certain conditions (such as limits, additional premium, co-payment, waiting period, etc.), or to grant a Lifetime Renewal Guarantee without imposing any conditions. If the product last used by the Insured who has become entitled to a Lifetime Renewal Guarantee has been withdrawn due to changes in legislation, force majeure, and/or by the Company, the renewal shall be made under another product that is parallel to or the closest equivalent of the coverages and contracted provider network contained in the previous policy.

In such a case, the Insured's existing Lifetime Renewal Guarantee right shall remain reserved. The renewal commitment is personal and applies only to the Insured who has acquired this right. The statement "Lifetime Renewal Guarantee Granted" shall be indicated in the certificate of each respective Insured. 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 on which the renewal commitment was granted, to conduct a new risk analysis assessment or to impose any new additional conditions such as additional premium, exclusion, or limit, except for the circumstances specified in Articles 6 and 7 of the General Conditions of Health Insurance.

If the Insured wishes to extend the scope of coverage during this period, the Insurer reserves the right to reassess the existing Lifetime Renewal Guarantee. The Health Policy offered by the Insurer to the Insured for whom a renewal commitment has been made shall be subject to the Special Conditions in force on the date on which the Policy acquired the renewal guarantee right. The Insurer reserves the right to make changes to the contracted provider network. However, for Insureds who were first insured before 23.04.2014 and who have either obtained or not yet obtained a renewal guarantee, the renewal guarantee shall continue to be granted under the title "Renewal Commitment Granted Without Re-Risk Assessment." For these Insureds, due to illnesses arising after the date on which the renewal guarantee was granted, the Insurer shall not have the right except for the circumstances specified in Articles 6 and 7 of the General Conditions of Health Insurance to conduct a risk analysis assessment or to impose any new additional conditions such as additional premium, exclusion, limit, or co-payment. However, for these Insureds, the additional premium application based on the claims/premium ratio, as specified in the Information Form and the Special Conditions, shall continue to apply. The renewal guarantee evaluation criteria described in the relevant clause shall also apply to these Insureds in the same manner.

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.