SPECIAL TERMS FOR LIFE-THREATENING CONDITIONS INSURANCE

These special terms are applicable to the Policy Holder who have MAPFRE Insurance Policy for Life-Threatening Conditions as of 01.12.2022.

ARTICLE 1 - SUBJECT MATTER OF THE INSURANCE

MAPFRE Sigorta A.Ş. ("Insurer") hereby provides coverage in case of developing a covered condition during the term of the insurance agreement, subject to the coverage limit, within the framework of these Special Terms and the attached General Terms of Health Insurance and the legal regulations including the Regulation on Private Health Insurance, Turkish Commercial Code, and health insurance legislation. Insurance coverage is valid only for the persons specified in the Insurance Policy; others cannot benefit from the coverage.

ARTICLE 2 – DEFINITIONS

START DATE: The day (12.00 pm at local time in Turkey), month and year when the Policy enters into force for the first time or upon each renewal.

END DATE: The day (12.00 pm at local time in Turkey), month and year in which this Policy expires.
WAITING PERIOD: The time frame in which no coverage is provided for the conditions covered, arising after the initial execution of the policy. Claims for life-threatening conditions which are diagnosed during the waiting period shall not be covered.

PRE-EXISTING BUT UNDECLARED HEALTH PROBLEM: Any existing and known complaint, symptom or disease not being declared to the Insurer, during or before the application for this Policy.

DOCTOR: A person who has the official title and document for "medical doctor", in line with the legislation applicable in the Geographical Region of the coverage, and who is given a working license by the Turkish Ministry of Health.

DEFERMENT PERIOD: For the Policy Holder to be entitled to the insurance claim as provided in the policy, he or she should survive for a certain length of time to follow the diagnosis of the life-threatening condition. This time frame is called the deferment period. In case the Policy Holder passes away during the deferment period, the beneficiaries shall not be provided insurance claim payments. The deferment period is set to be 30 days.

GENERAL TERMS: Written rules which are determined by the Turkish Prime Ministry Undersecretariat of Treasury and the application of which is obligatory in health insurances by all insurance companies.

HOSPITAL: A private or public entity holding an official hospital license in its field of business, providing medical services to sick and wounded persons. The following are not classified as hospitals: clinics providing outpatient treatment, sanatoriums, physical therapy centers, health clubs, nursing homes, care entities for the elderly, entities specialized in addiction (drugs, alcohol).

CANCELLATION DATE: The day, month and year on which the Policy is canceled upon a written request by the Policy Owner, or a withdrawal or termination by the Insurer in line with the provisions stipulated in the General Terms.

REGISTRATION DATE: The day (12.00 pm at local time in Turkey), month and year on which the Policy Holder is covered by the Insurance Policy, whether initially or by renewal with the terms specified in the renewal definition.

VALIDITY: The situation where the policy is reinstated following an assessment by the Insurer in case of cancellation of the insurance policy. If the application is submitted within 1 month as of the cancellation date, the validity process can be conducted.

SPECIAL TERMS: Terms prepared by the Insurance Company in addition to the Health Insurance General Terms and which state mutual rights and liabilities, coverages and validity terms and which are effective until the End Date of this Policy.

ADDITIONAL RISK PREMIUM: The application of additional premium for the risks associated with the conditions specified in the appendix to this Policy, and applicable only to the relevant Policy Holder as provided on the Policy. Applicable additional premiums are indicated on the relevant Policy Holder's policy, with justification and rates.

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POLICY OWNER: The person or legal entity who applies for an Insurance Policy, whose application is accepted by the Insurer and who is the responsible party under this Insurance Policy and acts in favor of themselves and the Persons to be Insured.

INSURANCE POLICY: Any and all documents bearing company stamps and authorized signatures, drawn up by the insurer subject to a specific format, specifying the policy's expiration date, general and special terms, limits, exemptions, and implementation details and payment terms, guaranteeing the payment of the coverage figures subject to the limits set, in case the conditions materialize.

INSURER: Insurance Company registered and holding an operating license in the country where the Insurance Policy is issued. For the purposes of this policy, the term insurer stands for MAPFRE Sigorta A.Ş.

POLICY HOLDER: Person and/or persons stated in the health insurance application of the Policy Owner and Persons to be Insured, or included afterwards, who are accepted by the Insurer and included in the Policy coverage, or who are included afterwards with an addendum.

STANDARD EXCEPTIONS: General exceptions which are specified in special conditions and apply to all Coverages and policy holders.

RENEWAL: The case where the Policy Owner contacts the Insurer within 30 days in advance of and 30 days to follow the End Date of the existing Insurance Policy, to execute a contract again, and the Insurer and the Policy Owner agree on the conditions of the new Insurance Policy upon which the new contract remains in force without interruption.

RENEWAL DATE: The Start Day (12.00 pm at local time in Turkey), month and year of the new Insurance Policy, which is the same as the End Date of the previous Insurance Policy.

ANNUAL TOTAL LIMIT: The maximum coverage figure provided by the Insurer on the Policy, subject to the terms of the present Insurance Policy.

MAPFRE CUSTOMER SERVICES: The hotline provided for access by the Policy Holder, by calling 0850 755 0 755 to submit their recommendations, requests and complaints, and to receive services.

ARTICLE 3 - COVERAGE

The following 14 diseases/surgeries are included within the Coverage of Life-Threatening Conditions Insurance.

1. Myocardial infarction (Heart Attack)
2. Cancer
3. Coronary Bypass Surgery
4. Kidney Failure
5. Stroke
6. Heart Valve Replacement Surgery
7. Organ Transplants
8. Arm or Leg Loss
9. Blindness
10. Hearing Loss
11. Multiple Sclerosis (MS)
12. Major Burns
13. Motor Neurone Disease
14. Surgery for Aortic Diseases

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DEFINITIONS REGARDING THE DISEASES INCLUDED WITHIN COVERAGE

1. MYOCARDIAL INFARCTION (HEART ATTACK)

Loss of viability in a certain part of the heart muscles due to inadequate blood flow. Diagnosis can be made based on the following signs:

a. Typical history of chest pain
b. Recently developed typical electrocardiographic changes
c. Typical enzyme elevations following infraction, i.e., troponins or other biochemical agents.

Exceptions: Myocardial infarcts without ST segment elevation in the presence of troponin I or T elevation (NSTEMI), other Acute Coronary syndromes.

2. CANCER

A disease that can be described as the presence of malignant tumors characterized by uncontrollable growth and spreading of cells, and tissue invasion. The term cancer also includes leukemia and other malignant diseases of the lymphatic system (such as Hodgkin's).

Exceptions:

• All premalignant and/or noninvasive tumors (in situ) (cervical cell changes (including CIN, ASCUS, HSIL, LSIL, etc.), ductal carcinoma in situ, prostate cancer stage 1 (1a,1b, 1c...etc.)

• Stage 1a (T1a N0 M0) malignant melanoma and all other types of skin cancer

• Stage I Hodgkin's disease,

• Any malignant tumor developing in the presence of HIV(AIDS).

• Chronic lymphocytic leukemia

3. CORONARY BYPASS SURGERY

A surgical procedure used to treat two or more blocked or constricted coronary arteries by placing a bypass graft. The necessity of surgical intervention must be proven by a coronary angiogram prior to the procedure.

Exceptions: Angioplasty and/or other intravenous interventions; keyhole surgery

4. KIDNEY FAILURE

The end stage of chronic kidney diseases that require regular peritoneal dialysis or hemodialysis treatment or kidney transplantation and cause unavoidable failure of both kidneys.

5. STROKE

The condition resulting from complete and irreversible loss of function in two or more of the spinal cord fibers following a disease or accident. A medical report including medical documents to indicate that the neurological damage is permanent and has been ongoing for at least 3 months should be presented as a document of proof in the claim for compensation.

Exceptions: strokes secondary to Guillain-Barre Syndrome.

6. HEART VALVE REPLACEMENT SURGERY

Surgical replacement of one or more heart valves with artificial heart valves. This surgery is performed in case of aortic, mitral, pulmonary and tricuspid valve stenosis, insufficiency or both.

Exceptions: Heart valve repairs, valvulotomy, valvuloplasty.

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7. ORGAN TRANSPLANTS

Cases where a major organ such as the heart, lungs, liver, pancreas, small intestine, kidney and bone marrow is transplanted to the recipient.

Exceptions: Cases where the involved party is the donor and all other organ transplants not specified above.

8. ARM or LEG LOSS

Complete and permanent loss of two or more extremities (arm and leg) or ankle and wrist disarticulation in two or more extremities (arm and leg) as a result of disease.
Arm or leg loss is an irreversible condition where two or more extremities (arm and/or leg) become completely unusable as a result of paralysis secondary to impact or disease.

9. BLINDNESS

Complete, permanent and irreversible loss of vision in both eyes as a result of accident or disease. In such a case, the pathology should be evidenced with a report prepared by an ophthalmologist.

10. HEARING LOSS

Complete, permanent and irreversible loss of hearing in both ears as a result of accident or disease. The diagnosis should be supported by audio tests and approved by an "Ear Nose Throat" specialist.

11. MULTIPLE SCLEROSIS (MS)

Multiple Sclerosis (MS) is a disease that progresses slowly and manifests with various neurological symptoms from numbness of the arms and legs to vision problems as a result of damage to the sheath of the central nervous system (brain, spinal cord) that enables the electrical impulses to be conducted along the nerves.
In order to make a final diagnosis of MS, the same neurologist should follow up the patient at a certain hospital for a certain period of time. The Policy Holder should exhibit neurological problems that have been ongoing for at least the last 6 months or at least 2 attacks that can be clinically demonstrated (Each attack should last at least 24 hours and should be observed for a month in different parts of the central nervous system). In addition, all these findings should be proven as loss of and decrease in motor and sensory functions and demyelination, and even typical MR images should be provided.

12. MAJOR BURNS

Third degree burns that cover at least 20% of the total body surface area of the Policy Holder (according to Wallace formula).

13. MOTOR NEURONE DISEASE

The final diagnosis of motor neurone diseases (for example, amyotrophic lateral sclerosis, primary lateral sclerosis, progressive spinal muscle atrophy, progressive bulbar palsy, pseudobulbar palsy) should be made by a neurologist at a certain hospital. The disease should restrict the person from doing at least three daily life activities (taking a bath, getting dressed-undressed, going to and using the bathroom, moving between the chair and bed, urinating, eating-drinking, speaking, swallowing drugs) or render the patient bedbound or unable to do tasks unassisted. All these symptoms should continue for at least 3 months and should be medically demonstrated.

14. SURGERY FOR AORTIC DISEASES

Can be defined as treating the chronic diseases of the aorta by surgical excision of a part of the vessel or placement of a graft into the impaired part of the vessel.

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ARTICLE 4 - STANDARD WAITING PERIODS

The claims associated with life-threatening conditions specified in policy coverage, arising after the initial execution of the policy, are excluded from coverage for a period of 6 months. The claims for such life-threatening conditions diagnosed within the said time frame shall be excluded, even if the claim is filed upon the expiration of the said time frame.

ARTICLE 5 - STANDARD EXCEPTIONS

In addition to the cases specified in the General Terms of Health Insurance, the cases excluded from the Life-Threatening Conditions Insurance Policy Coverage are as follows.

- The condition specified under the coverage being pre-existing as of the policy commencement date (with or without a diagnosis and/or treatment);
- Cases arising in connection with drugs or toxic substances (poisons) taken for suicide;
- Cases caused by evident intoxication, medications and drugs used outside the doctor's control;
- Cases arising out of professional sports activities and dangerous sports acts including but not limited to riding motorcycles, mountain climbing entailing rope climbing, scuba diving, airplane or glider piloting, and parachute jumping;
- Cases arising out of intentional injuries the Policy Holder inflicts on themselves;
- Cases caused by AIDS and related complications or HIV virus infections;
- Life-threatening conditions arising within 6 months to follow the policy commencement date;
- Claims to be made within the first month of the diagnosis of the life-threatening condition;
- Cases where the covered conditions are congenital;
- Claims in excess of the coverage limit specified on the policy;
- Healthcare expenses for occupational diseases and work accidents;
- Excluded cases specified in Article 3, under covered conditions;
- Any cases other than those specified in Article 3, under covered conditions.

ARTICLE 6 - GEOGRAPHICAL SCOPE

The coverage applies throughout the world. In case the conditions covered by the policy have been diagnosed in a country other than Turkey, the policy holder / policy owner shall be entitled to claim upon certifying that he / she was in the country where the treatment was applied, as of the date of treatment.

ARTICLE 7 - CLAIM PAYMENT

The Life-Threatening Conditions claims shall be paid provided that the preliminary information form and health declaration filled out by the policy holder under the General Terms of Health Insurance and Special Terms of Life-Threatening Conditions are accurate and complete. The policy holder should file the claim within a maximum of 6 months to follow the diagnosis of the conditions covered. The claim figure shall be paid by the end of the first 30-day period to follow the coronary by-pass surgery, the end of the 30-day period to follow the submission of the document certifying permanent neurological damage in case of strokes, or the end of the 30-day period to follow the diagnosis in case of other conditions covered, provided that the policy holder is still alive. If the policy holder passes away in this 30-day period, no claim shall be paid. A 30-day deferment period applies after diagnosis.

For coverage to be payable, the following documents should be submitted to the firm in full.

1. Original copy of the policy
2. Copy of the identity card
3. Medical certificate and examination results to serve as the basis of diagnosis
4. Examination reports to be issued by the hospitals or specialist doctors to be specified by **MAPFRE Sigorta A.Ş.**
5. If necessary, copies, tape records of the diagnostic procedures applied; the original copies of the diagnostic reports, etc.
6. Condition Information Sheet to be filled out by the policy holder

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7. The Medical Review Form filled out by the policy holder's doctor, and, if considered necessary during claims assessment, by the hospital or specialist doctor to be specified by **MAPFRE Sigorta A.Ş.**
8. Any medical information or evaluation required during the claims assessment, even if it was not specified here

ARTICLE 8 - RENEWAL OF THE CONTRACT AND THE LIFETIME RENEWAL GUARANTEE

8.1. INSURANCE PERIOD AND RENEWAL

Unless agreed otherwise, insurance starts at 12.00 pm and ends at 12.00 pm at local time in Turkey, on the days stipulated on the policy as start and end dates.
The Life-Threatening Conditions Insurance policy is executed for one year, and can be renewed with the approval of the Company at the end of each policy year, based on the policy owner's statement and in consideration of the payment of the full figure of the premium to be established with reference to the Company's premium rates in effect as of the date of renewal, subject to the General Terms and Special Terms offered by the insurance company for this policy, where necessary, with the condition of proving insurability to the insurance company in a satisfactory manner.

8.2. LIFETIME RENEWAL GUARANTEE

No Lifetime Renewal Guarantee is extended for this policy.

ARTICLE 9 - DETERMINING THE PREMIUM

The policy premium is calculated on an actuary basis, with reference to the age as of the insurance start date (the difference between the start date and the date of birth as day/month/year), gender, and the coverage limit set.

9.1. PREMIUM PAYMENTS

Premium Payments The form of payment, term, and the amount of the insurance premium are stated on the application form and/or the premium payment form. The Policy Holder can pay the premiums in advance and/or in installments in line with the payment plan approved by the Insurer, by choosing one of the collection options below. The responsibility to make payments as stated on the policy and on the related due dates lies with the Policy Owner, or if any, the Policy Holder.

ARTICLE 10 - NEW ENTRY PROCEDURES

10.1. INSURANCE PERIOD AND ACCEPTANCE FOR INSURANCE

The insurance period is 1 year and shall cover the period between the start and end dates specified in the policy. Insurance coverages enter into effect with the acceptance of the application and issuance of the policy by the Insurer, and the payment of the down payment.

Applicants in the 18 - 60 years old age range are eligible for this insurance scheme.

10.2. APPLICATIONS

Initial and any subsequent applications of the Policy Owner/Policy Holder applicants must be made using the application forms provided by the Insurer, and the declaration sections related to the Persons to be Insured should be filled in completely and accurately. All applications and/or change requests to be made for an Insurance Policy must be in writing and bear a wet signature. Any amendment or scratch on the application form is not accepted.
MAPFRE Sigorta A.Ş. reserves the right to refuse the initial or any subsequent applications, or accept them under terms acceptable to it. MAPFRE Sigorta A.Ş. shall provide justification for its decision, but shall not be required to prove it.

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10.3. RESPONSIBILITY OF THE POLICY OWNER

The Policy Owner is under obligation to return any documents issued in the name of any excluded persons to the Insurer, in case the Policy Holder is excluded from policy coverage or in case the policy is cancelled.

Losses that shall be incurred because the documents were not returned in full shall be claimed from the Policy Owner in recourse. The Policy Owner/Policy Holder is obliged to answer the questions asked in the application form and complementary documents, and to declare the information that constitutes the subject of the risk and/or that will be effective in its assessment.

If the declaration by the Policy Holder/Policy Owner is false, incomplete or inaccurate, the provisions of Article 6 of the General Terms of Health Insurance shall apply. The insurer has the right to collect from the Policy Holder and/or the Policy Owner the payments made outside the scope of coverage in violation of the General and Special Terms of Health Insurance under the policy.

ARTICLE 11 - TRANSFERS AND VESTED INTERESTS

Any requests for renewal or the preservation of vested interests to be submitted through another Insurance Company, with respect to this product, shall be disregarded. The Insurer shall review the requests as the initial insured.

ARTICLE 12 - PRINCIPLES OF INSURANCE CONTRACT EXPIRY

12.1. CANCELLATIONS

If the Policy Owner/Policy Holder requests cancellation within 30 days following the drawing up of the policy, the policy shall be canceled as of its start date, provided that no risks have materialized, and the paid-in premiums shall be refunded in full to the Policy Holder. For requests delivered after 30 days but approved by the Insurer, the Insurer is entitled to collect premium based on the number of days, from the start date of the policy to the cancellation date. The amount to be returned to the Policy Owner/Policy Holder due to cancellation is calculated based on days by taking paid indemnity into consideration. If the indemnity payments made to the Policy Holder 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 Policy Holder. If the indemnities that are paid to the Policy Holder exceed the premium amount that the Insurer is entitled to, but do not exceed the premium amount collected by the Insurer, then the Insurer will deduct such indemnity amount from the premiums they collected and return the remaining premium to the Policy Holder. If the indemnity amount paid to the Policy Holder exceeds both premium amount that the Insurer is entitled to have and the premiums paid by the Policy Holder, cancellation is done without refunding the premiums. Even if the premiums are not due yet when the risk occurs, the portion corresponding to the indemnity amount that the Insurer is obliged to pay becomes due and payable.

The Policy Owner shall be in default in case of its failure to pay any premium the exact due dates and amounts of which are indicated on the policy, by its maturity. The provisions of Article 1434 of the Turkish Commercial Code shall apply if the premium debt is not paid on time. If the Insurer catches the Policy Holder/Policy Owner acting in bad faith (making persons not covered by the policy benefit from the insurance coverage, misrepresentation of health expenditures as costs incurred by other insured persons, discovery of medical conditions known to the applicant before the insurance start date but deliberately not reported to the Insurer, etc.) the Insurer has the right to claim the health expenses they paid for and/or to cancel the Policy without a premium refund.

12.2. DEATH OF THE POLICY OWNER OR THE POLICY HOLDER

In the event of the death of the Policy Owner and/or the Policy Holder, the Insurer shall proceed in accordance with the following circumstances. In the event of the death of the Policy Owner, the Insurer must be furnished with written approval of lawful heirs of the Policy Owner, if the Policy Owner and the Policy Holders on the policy are different and if the Policy Holders wish to continue on the same policy by revising the Policy Owner. In that case the policy shall remain in effect with a change of the Policy Owner. In the cases where the approval of lawful heirs is not received, the procedures are applied in line with the cancellation stated above and the premium return is made to lawful heirs, if any. The personal policies where the Policy Owner and the Policy Holder are one and the same shall become null and void upon the death of the Policy Owner. The policy owner's policy is processed in accordance with the cancellation criteria set out above upon the written request of his lawful heir and the premium, if any, is refunded to the lawful heir. In cases where more than one person is insured, in the event of the death of one of the Policy Holders, it releases the person who has passed away from the policy as of the date of death. Any premium refunds to arise in accordance with the cancellation criteria specified above shall be provided to the Policy Owner.

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ARTICLE 13 - POLICY REVISIONS

During the policy term, the Policy Holder / Policy Owner shall not procure any revision regarding the contents and the amount of the coverage provided, such as the addition or removal of coverage extended under the policy or the reduction or increase of the coverage figures. Such requests shall be taken into consideration only at the time of policy renewal.

MAPFRE Sigorta A.Ş. reserves the right to revise the special terms and tariff applicable at each contract execution period.

ARTICLE 14 - SAGMER (INSURANCE OVERSIGHT CENTER) NOTIFICATION

The policy and health information of the Policy Holders in this insurance policy will be transferred to SAGMER (Insurance Oversight Center), and the policy and health information of the Policy Holders will also be able to be obtained from SAGMER and other public institutions.