mapfre Sigorta

# HEPSİ BİRLİKTE HEALTH INSURANCE INFORMATION FORM

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

This form, issued in three copies, has been prepared pursuant to the Regulation on Information in Insurance Contracts published on 28/10/2007, in order to provide general information to the Policyholder and other beneficiaries of the insurance regarding their rights and obligations, the subject and functioning of the contract, as well as certain significant changes and developments, both during the negotiation of the insurance contract and throughout the term of the insurance.

## A - COVERAGES

1. The Insurer shall provide coverage, within the coverage, limits, co-payment rates and practices specified in the policy/endorsement, and in accordance with the Turkish Commercial Code, General Provisions, General Conditions of Health Insurance and Special Conditions, for expenses incurred for the diagnosis and treatment of the Insured/Insured persons as a result of an illness and/or accident that may occur within the start and end dates specified in the policy/endorsement.

2. The parties have the right to agree on special conditions in addition to the general insurance conditions, provided that such conditions are not contrary to the law or morality and are not to the detriment of the Insured. Your health insurance policy may vary depending on the product and coverages you have selected. All coverages related to the products are set out below.

**a.Outpatient Treatment Cov.**

| | | | | |
|---|---|---|---|---|
| CHI Doctor Consultation | TSS | Laboratory | CHI Advanced Diagnostics | CHI Radiology |
| CHI Physical Therapy | | | | |

**b.Inpatient Treatment Coverages**

| | | | |
|---|---|---|---|
| Surgery/Hospitalization | Chemotherapy | Intensive Care | Hospital |
| Surgeon's Fee | Dialysis | Radiotherapy | Room & Companion |
| Post-Hospitalization Physical Therapy and Rehabilitation | Emergency Diagnosis | | Minor Intervention |

**c.Other Coverages**

| | | | |
|---|---|---|---|
| Home Care | Maternity | Artificial Limb | Overseas Inpatient Treat. |
| PSA/Mammography Screening | Check Up | Auxiliary Medical Equipment | |
| Air/Ground Ambulance | Outpatient Support Treatment | | |

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Coverages and waiting periods may vary depending on the characteristics of the selected product and plan. In addition to those specified in the general and special policy conditions, the insurance company may, on a policy basis and in accordance with its own underwriting principles, exclude certain conditions, diseases or accidents from coverage by applying specific exclusions, taking into account the declarations made at the time of the policy application. For optional additional coverages, please consult your customer representative. Please read and verify the coverages specified in your quotation and policy.

## B - POLICY PREMIUM CALCULATION

In accordance with the Insurer's Risk Acceptance Regulation, the premium of the prospective Insured is calculated based on the tariff sales premiums determined by the Company and announced across all sales channels, taking into account the selected plan and coverages, the Insured's age and gender, health inflation, and the loss/premium ratio of the relevant age group within the portfolio. In the event that, after the insurance commencement date, a spouse or child is to be added under the family coverage or the Insured requests a change of plan, such request shall be processed based on the premiums in force as of the request date, provided that the Insurer reserves the right not to accept the relevant request. The premiums, discounts and payment terms of the Insured are specified on the front page of the policy. The policy premium is calculated based on the age at the Insurance Commencement Date (calculated as the difference between the commencement date and the date of birth in terms of day/month/year)..

## DISCOUNTS AND ADDITIONAL PREMIUMS

MAPFRE Sigorta A.Ş. calculates the applicable discount and additional premium rates for policies that meet the conditions set out below and issues the Insurance Policy accordingly.

### 1 - NO-CLAIM DISCOUNT

The No-Claim Discount application consists of a total of 8 levels, including an entry level and 7 discount levels. Insured persons who obtain a policy as new business or via transfer start from the entry level (Level 1). Taking into account the Insured's current policy period level and the "Claim"/"Health Net Premium" (C/P) Ratio, the level of the renewal policy for the following year is determined.
For Insured persons whose coverage period in the previous year was less than 6 months on a pro rata (daily) basis, the starting level shall be Level 1. The level of the renewal policy is determined by taking into account the Insured's current policy period level and the "Claim"/"Health Net Premium" (C/P) Ratio.

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

The discount rates applicable to each level are 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, at rates varying according to the policy years, upon the renewal of the Insured's uninterrupted policies. The loyalty discount is not applied in cases of transition from a group health policy to an individual health policy.

### 3 - FAMILY DISCOUNT

A family discount shall be applied where the individual health policy consists of mother, father and children, and the number of insured persons under the policy is at least two or more. The family discount shall apply even if different plans or products are selected within the same family.

### 4 - REGIONAL (PROVINCE) DISCOUNT

The regional discount is granted automatically by the system based on the province in which the individual resides.

### 5 - FIRST INSURANCE DISCOUNT

A first insurance discount shall be applied to Insured persons who are included in an individual health insurance policy for the first time and are subject to a waiting period.

### 6 - RISK ADDITIONAL PREMIUM

These are additional premiums applied by the insurance company based on the Insured's risk, following an assessment conducted in line with the declarations made in the Application Form and/or the information and documents obtained. The Risk Additional Premium may be applied to all coverages and/or to certain coverages. The applicable Risk Additional Premium may be up to a maximum of 200%. Approval of the Policyholder and/or the Insured is mandatory for any additional risk premium requested during the risk assessment process..

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## C - GENERAL INFORMATION AND WARNINGS

1. Health insurance policies provide coverage for individuals older than 14 days and under the age of 64 (inclusive).
2. The Policyholder/Insured must submit their request for insurance by completing the Application Form fully and accurately, and the Application Forms must bear wet signatures. In addition, even if not explicitly requested in the Application Form, you are under an obligation to disclose, at the time of application, any other matters known to you that may affect the assessment of the risk subject to the contract. It is mandatory to notify the Insurer, within due time, of any changes occurring after the conclusion of the contract. Please note that providing incomplete or inaccurate information may result in the loss of your right to indemnity or lead to adverse consequences; therefore, you must refrain from providing incomplete or incorrect information to the Insurer at any stage of the contract. Any unanswered questions in the Application Form shall be deemed to have been answered as "NO."
3. The Insurer may, if deemed necessary at the time of the initial conclusion of the contract, request a medical opinion to assess the health condition 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 specific conditions. In the event of rejection of the application, the Application and Information Form shall become null and void.
4. Policy cancellation procedures are processed based on the written declaration of the Policyholder. Upon completion of the relevant process, the Information Form attached to the Application Form shall become null and void as of the effective date of the additional document.
5. Pursuant to Article 8 of the General Conditions of Health Insurance, in the event of default in the payment of premiums in health insurance, the provisions of the Code of Obligations shall apply.
6. In order to prevent potential disputes in the future, please ensure that you obtain a receipt if you make a cash down payment of the premium.
7. Premiums paid for insurance may be tax-deductible. Please consult your Insurer on this matter.
8. After the conclusion of the contract, any changes made, without the Insurer's consent, to matters that may affect the risk must be notified to the insurance company within eight days, in accordance with Article 7 of the General Conditions of Health Insurance.
9. If any of the Insured persons covered under an individual policy engages in any act that is contrary to the general policy conditions and implementation principles, or attempts to obtain unjust benefit intentionally, the policies of all Insured persons under the policy shall be cancelled immediately. During the ongoing policy period, the Insurer may conduct a second risk assessment based on the Insured's identified health condition (including incomplete and/or incorrect declarations or non-disclosure) and may determine a new conditional acceptance (such as exclusions, additional premiums, limits, standard terms, etc.) in relation to the identified condition.

10. Even if the Company has obtained information regarding the Insured from the treating persons and institutions, the Insurance Information and Monitoring Center, and public institutions and organizations, if a medical opinion is still required, the relevant costs shall be borne by the Insurer. However, if the contract is concluded solely based on the health declaration provided by the Insured/Policyholder, any required medical opinion costs shall be borne by the Insured/Policyholder.
11. For more detailed information regarding the insurance, please carefully read the Special and General Conditions of Health Insurance.
12. The Insured's exclusions, coverages, limits, co-payment rates, plan details, etc. are specified in the policy.
13. Unless otherwise agreed, the insurance shall commence at 12:00 noon (Turkey time) on the date specified in the policy as the start date and shall end at 12:00 noon on the end date, and in any case upon the occurrence of the risk.
14. The Insurer shall complete the claims process within a maximum of 10 days following the receipt of all required information and documents in full.
15. In the event that the contact information provided in the Application Form is incomplete or incorrect, the responsibility shall not lie with the insurance company due to the inability to provide notifications. In order for us to reach you more easily, please notify any changes to your identity, address, telephone, etc. information available in our system via musterihizmetleri@mapfre.com.tr or by fax to +90 212 334 62 60.
16. You can access all information regarding your policy through the Insured Online system 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 its network during the policy period or to remove any such contracted institution entirely from the network.

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## D - EXCLUSIONS

The cases excluded from coverage as specified in Article 2 of the General Conditions of Health Insurance, as well as the situations listed below, are excluded from all coverages under this Policy. However, the cases listed between Articles 39 and 49 shall be evaluated within the scope of the Policy only for outpatient treatment expenses, provided that the Insured has acquired the right to Lifetime Renewal Guarantee prior to 01.10.2023, the relevant expenses are covered by the Social Security Institution (SSI), and there is no specific exclusion in the policy regarding this matter.

1. The diseases specified in this article are excluded from coverage; however, these exclusions shall not apply if the Insured has completed at least 3 consecutive years of uninterrupted individual insurance coverage with our Company and has become entitled to the Lifetime Renewal Guarantee, or if the Insured is covered as a MAPFRE Baby:

**a.**Congenital and genetic diseases identified after the Policy Start Date, even if they manifest at an advanced age, and, unless otherwise agreed, expenses related to premature infants (even if the baby has been insured from birth), except where the neonatal incubator additional coverage has been purchased and the relevant coverage conditions are met.

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

**c.**Treatments for dementia due to old age, Alzheimer's disease, Parkinson's disease, and epilepsy.

**d.** Operations related to the nasal septum and turbinate.

**e.**Operations related to the nasal septum and turbinate are valid only at the Contracted Health Institutions specified on the MAPFRE Sigorta website, which are specially designated by the Insurer under the name "ENT Network," regardless of the type of Contracted Health Institution applicable under the Policy. In cases where the Insured's treatment is performed by a non-contracted physician at a Contracted Health Institution within the ENT Network, the physician's fee shall be paid up to the amount specified in the HUV Tariff (HUV*1). However, if the Insured has completed at least 5 consecutive years of uninterrupted individual insurance coverage with our Company and has become entitled to the Lifetime Renewal Guarantee, such operations shall be valid at all Contracted Health Institutions covered under the Policy. In such cases, if the treatment is performed by a non-contracted physician at a Contracted Health Institution, the physician's fee shall be calculated in accordance with the limits and co-payment rates applicable to non-contracted institutions under the "Surgeon and Physician Fees" coverage.

2. If the Insured has completed at least 5 consecutive years of uninterrupted individual insurance coverage with our Company and has become entitled to the Lifetime Renewal Guarantee, or if the Insured is covered as a MAPFRE Baby, treatments related to strabismus, otosclerosis, keratoconus, and ptosis that arise after the initial policy registration date shall not be considered as exclusions; however, they shall be valid only at Contracted Health Institutions within the C network, regardless of the network specified in the Insured's policy. For Insured persons who have not completed 5 years under an individual policy with our Company and have not become entitled to the Lifetime Renewal Guarantee, such treatments are excluded from coverage. Contracted Health Institutions within the C network can be accessed via the "Contracted Health Institutions" page on the MAPFRE Sigorta website.

3. Expenses related to premature neonatal incubator care for a newborn baby of an Insured who has not completed the maternity waiting period or who is covered under a plan without maternity coverage.

4. Any health expenses related to pre-existing conditions/diseases that existed prior to the initial policy registration date with MAPFRE Sigorta and were not disclosed, including recurrences and complications of such conditions (regardless of whether they had been diagnosed and/or treated).

5. Any tests related to the investigation of genetic diseases/conditions, gene mapping, and genetic screening.

6. Any accidents resulting from driving without a valid driver's license and all expenses related to such accidents.

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

8. All hazardous sports activities, whether performed on an amateur or recreational basis or otherwise, and/or hazardous activities not limited thereto, such as mountaineering, diving with breathing apparatus, piloting aircraft and gliders, parachuting, paragliding, hang gliding, horseback riding, rafting, street luge, high-altitude jumping sports (base jumping), kiteboarding, kitesurfing, underwater sports, mountain biking, motorcycle and automobile sports, and the use of electric scooters, electric bicycles and electric motorcycles not requiring a license, skiing, and the use of motorcycles as a driver or passenger even for transportation purposes, together with expenses arising from any professional and/or licensed sports activities, are limited to TRY 40,000. Among these activities, only skiing and the use of motorcycles and ATVs as a driver or passenger for transportation purposes, provided that the driver holds a valid license, may be covered within the policy limits and coinsurance rates, subject to an additional premium and provided that the risk has not yet occurred.

9. 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 drinking cures, etc.), regardless of the institution where they are performed, as well as treatments administered in spa and thermal facilities, sanatoriums, nursing homes, care homes, preventoriums and rehabilitation centers, are excluded from coverage.

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

11. Procedures/treatments under Inpatient Treatment Coverage that do not have a corresponding entry in the HUV (Medical Practice Database).

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12. Any procedures performed and all related expenses (including examination, tests, diagnosis, treatment, etc.) at aesthetic, cosmetic, laser and beauty centers; lens and optical centers; centers 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; podiatry and similar centers are excluded from coverage.
13. Any procedures performed by physicians without a Ministry of Health operating license and by persons who are not medical doctors, and all related expenses, are excluded from coverage.
14. Expenses related to nasal valve surgery are excluded from coverage.
15. Expenses incurred for obtaining medical board or physician reports for purposes such as pre-sports participation, pre-marriage, or pre-employment are excluded from coverage.
16. Invoices issued by the Insured's first-degree relatives are excluded from coverage.
17. Expenses incurred for the removal of the Insured's specific exclusions are excluded from coverage.
18. Expenses related to inpatient treatments deemed not medically indicated based on reports received from the hospital by the MAPFRE Sigorta Medical Procedures Center, as well as diagnostic and treatment procedures not associated with a specific complaint and/or disease or unrelated to the complaint, are excluded from coverage.
19. All examination and treatment expenses related to uvuloplasty, snoring, and sleep apnea are excluded from coverage. (All expenses related to uvuloplasty and sleep apnea shall be covered for Insured persons who acquired the Lifetime Renewal Guarantee prior to 01.10.2023.)
20. All examination and treatment expenses related to scoliosis and all spinal curvatures are excluded from coverage. (Scoliosis and all spinal curvatures shall be covered for Insured persons who acquired the Lifetime Renewal Guarantee prior to 01.10.2023.)

21. Expenses related to umbilical cord cysts, hydrocele, and all hernia procedures for children under the age of 7 are excluded from coverage (This provision shall not apply to MAPFRE Babies as an exception).

**22.** Medical materials not covered under the Auxiliary Medical Equipment Coverage defined in Article 3.1.13; CPAP devices, their calibration and monitoring; home-use humidifiers; externally attached devices (such as hearing aids, cochlear implants, etc.); injectors not administered with medication; bandages; and other expenses not required for treatment such as telephone, TV, cafeteria, administrative services, paramedical services and service charges; as well as all expenses related to external and supportive prostheses that cannot be considered within the scope of Inpatient Treatment Coverage are excluded from coverage.

**23.**All examination, treatment and complication expenses related to elective curettage, infertility (sterility), investigation of miscarriage and the facilitation of pregnancy (including in vitro fertilization, follicle tracking, microinjection, tuboplasty, etc.), as well as hysterosalpingography (HSG), spermiogram and adhesiolysis expenses, are excluded from coverage.

**24.** All expenses related to circumcision and phimosis, even if medically necessary, are excluded from coverage.

**25.** Expenses related to superficial varicose vein treatments such as sclerotherapy, chemical blockage, laser, radiation, massage, compression stockings, etc., are excluded from coverage.

**26.** Expenses related to the collection and storage of cord blood and stem cells are excluded from coverage.

**27.** All expenses related to officially declared epidemics and epidemics initiated with malicious intent are excluded from coverage.

**28.**Participation fees payable by the Insured pursuant to Article 98/2 of the Social Insurance and General Health Insurance Law No. 5510 are excluded from coverage.

29. Private nursing expenses not approved by the MAPFRE Sigorta Medical Procedures Center (except those covered under the Home Care Coverage), ambulance expenses other than in Emergency Situations (as defined in Article 2 – Definitions), and all expenses related to auxiliary healthcare personnel (such as physiotherapists, respiratory therapists, caregivers, etc.) are excluded from coverage.
30. All expenses related to examinations performed by dentists and maxillofacial surgeons, dental and gum treatments and jaw treatments, as well as expenses for toothpaste, oral and dental care products, etc., are excluded from coverage.

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

**32.** Except for those evaluated under the Home Care Coverage, all usage/rental fees for medical materials and/or devices are excluded from coverage.

**33.** For procedures evaluated under outpatient diagnosis/treatment coverage, health expenses incurred during periods when the General Health Insurance provided by the Social Security Institution is not active due to reasons such as termination of employment or non-payment of insurance premiums are excluded from coverage.

**34.** Health expenses incurred outside the Contracted Health Institutions specified in the Policy and evaluated within the scope of Outpatient Treatment are excluded from coverage.

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

**36.** Within the scope of outpatient treatments, including the "Green Area" application, all medication expenses, materials and contrast agents used for diagnostic tests, material costs, and vaccination expenses are excluded from coverage.

**37.** Travel expenses, daily allowances, fees for a second companion, suite room differences, and personal expenses are excluded from coverage.

**38.**All expenses incurred abroad within the scope of Outpatient Treatment Coverage are excluded from coverage.

**39.**All examination and treatment expenses related to structural disorders, motor-mental development and growth disorders (such as delayed/advanced growth and development, early/late puberty, etc.) are excluded from coverage.

**40.**Mental illnesses requiring psychiatric treatment, psychological disorders, neuropsychiatric tests, all forms of psychotherapy, and all related expenses are excluded from coverage.

**41.** Expenses related to screening tests such as coronary artery calcium scoring, coronary CT angiography, EBT (Electron Beam Tomography), as well as virtual angiography and virtual colonoscopy are excluded from coverage.

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

**43.** All expenses related to the diagnosis or treatment of obesity, weight and appetite disorders, including surgical procedures and complications, dietitian services, and weight loss or weight gain programs are excluded from coverage.

**44.**Examination, diagnosis, treatment and complication expenses related to physicians providing balanced nutrition, diet-exercise programs, and alternative and/or complementary treatments are excluded from coverage.

**45.** Hearing impairment surgery (except for procedures such as tube insertion, tympanoplasty, sequelae of chronic otitis, etc.) and all related examinations and treatments, as well as speech and language therapies, are excluded from coverage.

**46.** Except for Insured persons under the age of 18, all expenses related to varicocele, whether related to infertility or not, are excluded from coverage.

**47.** All examinations and treatments related to gender reassignment operations, erectile dysfunction, Peyronie's disease, penile chordee, vaginismus, sexual dysfunctions (including penile prosthesis), and expenses related to contraceptive methods (such as pills, condoms, etc.) not falling within the scope of Article 3.4.3 are excluded from coverage.

**48.** All examination and treatment expenses related to syphilis, anogenital condylomas, HIV, and AIDS, regardless of the mode of transmission, are excluded from coverage.

**49.** Expenses related to the donor in organ, tissue and blood transplantation are excluded from coverage.

E - STANDARD WAITING PERIODS

The conditions listed below shall be excluded from coverage for all treatments during the specified waiting periods, unless they arise as a result of a judicial accident, starting from the Insured's Registration Date. Provided that the Insurance Policy is renewed in accordance with the renewal conditions and no specific exclusion is imposed by the Insurer for any of the conditions listed below, such conditions shall be included in coverage thereafter.

**Conditions Subject to a 6-Month Waiting Period (Unless Arising from a Judicial Accident)**

1. All types of hernias.
2. Anorectal diseases (such as hemorrhoids, anal fistula and fissure, anal abscess, etc.) and pilonidal sinus (sacral dermoid cyst).
3. Tonsillectomy, adenoid vegetation surgery, tympanic membrane surgery and tube insertion, and sinus surgery.

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4. All benign tumors, space-occupying lesions, nevi, polyps and hyperplasia excisions, etc.
5. Thyroid and parathyroid diseases.
6. Diseases and operations related to the cervix, uterus, ovaries and fallopian tubes, endometriosis, and cystorectocele.
7. Hydrocele, spermatocele, cord cyst and epididymal cyst.
8. Spine and disc diseases, all joint disorders (knee, shoulder, etc.), trigger finger, ligament and tendon disorders, carpal tunnel syndrome, tarsal tunnel syndrome.
9. Varicose veins and venous thrombosis.
10. Stone diseases of the urinary system and prostate surgeries.
11. All endoscopic and laparoscopic procedures and angiographies (excluding 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 (including hypertension, ulcer, reflux, inflammatory bowel diseases (ulcerative colitis, Crohn's disease, etc.), COPD, asthma, diabetes mellitus, demyelinating diseases, myasthenia gravis, sarcoidosis, nephritis, all rheumatic and connective tissue diseases).
15. Waiting Period for Maternity Coverage: A waiting period of 9 months shall apply to all conditions within the scope of maternity coverage (including routine pregnancy check-ups, normal or cesarean delivery, miscarriage and/or any complications arising therefrom, etc.). This period shall commence as of the initial effective date of the Insured's maternity coverage. In the calculation to be made under maternity coverage, the Insured's last menstrual period shall be taken into account. The last menstrual period must be after the start date of the maternity coverage and must be consistent with the ultrasonography findings obtained during pregnancy follow-up.

Conditions Subject to a 3-Month Waiting Period for Outpatient Treatment Coverage

All health expenses related to physical therapy and rehabilitation within the scope of Outpatient Treatment Coverage shall be subject to a waiting period of 3 months as of the date the coverage is purchased.

## F - TRANSFER PROCEDURES AND ACQUIRED RIGHTS

When the Insurer renews a Policy as a transfer from another company, it has the right to request a health declaration from the Insured and to apply conditional acceptances (such as limits, Risk Additional Premium, co-payment, waiting periods, etc.), provided that the conditions of the Lifetime Renewal Guarantee, if any, are reserved. For Insured persons transferring from another company with a Lifetime Renewal Guarantee, the Lifetime Renewal Guarantee conditions of our Company shall apply.

Diseases of the individual that existed in other insurance company/companies and/or that are determined to have existed prior even to the initial insurance date shall not be considered within the scope of acquired rights if they were not declared in the application form, even if they had been covered by the previous insurer. Such conditions are excluded from coverage.

Acquired rights only refer to the removal of waiting periods specified in the special conditions, the preservation of the initial registration date, and, if applicable, the transfer of the Lifetime Renewal Guarantee.

Rights included in the special conditions/coverages of the Insured's previous policy but not included in the special conditions/coverages applicable to the new insurance period shall not be considered as acquired rights. However, rights that are included in the special conditions applicable to the new period but were not included in the previous period shall also apply to the Insured. In order for the Insured's acquired rights to be preserved, an application must be made no later than 30 days from the policy expiry date.

## G - LIFETIME RENEWAL GUARANTEE

Provided that the Insured maintains uninterrupted insurance with MAPFRE Sigorta A.Ş. under the same product for a period of 3 years and the average Claim/Premium ratio over the last three years remains below 80%, a "Lifetime Renewal Guarantee" shall be granted to the Insured holding a Health Policy, subject to the conditions to be determined as a result of the risk assessment. In order to carry out the evaluation for the Lifetime Renewal Guarantee, the Insurer may request from the Insured an application form containing current health information and, if deemed necessary, medical reports. In line with the applicable Risk Acceptance Regulation and depending on the health condition, the Insurer reserves the right to accept the Insured by applying conditional terms (such as limits, Risk Additional Premium, exclusions, co-payment, waiting periods, etc.) or to grant the "Lifetime Renewal Guarantee" without applying any conditions.

The renewal guarantee is personal and applies only to the Insured who has earned such right. The "Lifetime Renewal Guarantee" granted by the Insurer shall be specified in each Insured's Policy.

For policies to be transferred from another insurance company to MAPFRE Sigorta A.Ş., a risk assessment shall be conducted for the Insured regardless of whether a renewal guarantee exists, and applications such as limits, co-payment, exclusions, Risk Additional Premium, etc. may be applied. However, the Risk Additional Premium applicable per illness shall not exceed 200%.

The renewal guarantee right acquired from the previous insurer shall be re-evaluated in accordance with the criteria of MAPFRE Sigorta A.Ş., and within the framework of the risk assessment to be conducted, the Insured's renewal guarantee right may be continued under the Insurer's current special conditions.

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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 guarantee was granted, to conduct a risk assessment or to impose new additional conditions such as Risk Additional Premium, exclusions, limits, or co-payment, nor to apply additional premiums based on the claim/premium ratio, except for the circumstances specified in Articles 6 and 7 of the General Conditions of Health Insurance.

During this period, if the Insured requests to expand the scope of coverage, the Insurer may conduct a new risk assessment for the coverage to be added or modified and may apply conditions such as limits, co-payment, exclusions, Risk Additional Premium, etc. The Insurer also reserves the right to reject such request.

The Health Policy provided by the Insurer to Insured persons for whom it has undertaken a renewal guarantee shall be subject to the Special Conditions in force as of the date on which the Policyholder acquired the right to the Lifetime Renewal Guarantee.

For Insured persons who do not have a Lifetime Renewal Guarantee, the Special Conditions of the Policy in force for each Policy Period shall apply.

## H - CANCELLATIONS

If the Policyholder/Insured requests cancellation within 30 days from the date of issuance of the policy, and provided that the risk has not occurred, the policy shall be cancelled as of the Policy Start Date and the premiums paid shall be refunded to the Insured without any deductions.

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

If the indemnity paid to the Insured exceeds both the premium amount to which the Insurer is entitled and the premiums paid by the Insured, the policy shall be cancelled without any premium refund. Upon the occurrence of the risk, the portion of the premium corresponding to the indemnity amount payable by the Insurer shall become due, even if the premium installments have not yet matured. If the Policyholder fails to pay any of the premiums specified in the policy, including their definite due dates and amounts, by the due date, the Policyholder shall be deemed in default. In the event of non-payment of the premium debt on time, the provisions of Article 1434 of the Turkish Commercial Code shall apply.

In cases where the Insurer determines that the Insured/Policyholder has acted in bad faith (such as enabling non-insured persons to benefit from insurance coverage, arranging medical expenses under the names of other Insured persons, or identifying undisclosed pre-existing conditions known to the Insured and/or with symptoms existing prior to the insurance commencement date), the Insurer shall have the right to recover the health expenses it has paid and/or to cancel the policy without any premium refund.

# HEPSİ BİRLİKTE HEALTH INSURANCE INFORMATION FORM

## I - DEATH OF THE POLICYHOLDER OR THE INSURED

In the event of the death of the Policyholder and/or the Insured, the Insurer shall proceed in accordance with the conditions set out below. In the event of the death of the Policyholder: if the Policyholder and the Insured/Insured persons under the policy are different, and the Insured persons wish to continue the policy by changing the Policyholder, the written consent of the Policyholder's legal heirs must be submitted to the Insurer. In such case, the Policyholder shall be changed and the policy shall continue accordingly. If the consent of the legal heirs is not obtained, the process shall be handled in accordance with the cancellation criteria set out above, and any applicable premium refund shall be paid to the legal heirs.

In a single-person policy where the Policyholder and the Insured are the same person, in the event of the death of the Policyholder, the policy shall become null and void. Upon the written request of the legal heirs of the Policyholder, the process shall be carried out in accordance with the cancellation criteria set out above, and any applicable premium refund shall be paid to the legal heirs.

In policies covering more than one Insured person, in the event of the death of one of the Insured persons, the deceased Insured shall be removed from the policy as of the date of death. Any applicable premium refund shall be made to the Policyholder in accordance with the cancellation criteria set out above.

## İ - RENEWAL OF THE CONTRACT

This insurance is valid for a maximum period of 1 year. However, following the policy expiry date, a new policy may be issued upon the request of the Insured/Policyholder and in accordance with the principles determined by the Insurer. If a change of plan is requested during the renewal period, a Health Declaration Form may be required.

The Insurer shall determine the renewal conditions by evaluating the health condition of the Insured during the coverage period and/or the claim/premium ratio, in respect of Insured persons who do not have a Lifetime Renewal Guarantee.

In the event that the Insurer applies conditional acceptances (subject to the provisions of the Lifetime Renewal Guarantee, if any) for conditions existing in the previous period and/or ongoing illnesses in the new contract, such conditional acceptances shall remain valid as long as the policy is renewed and not declared null and void by the parties.

During renewal, the Policyholder may apply to the Insurer to extend the Scope of Coverage under 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 subject to conditions (such as Risk Additional Premium, limits, co-payment, etc.). Waiting periods shall recommence for newly added coverages. In addition, policies shall be renewed based on the current premiums, tariffs, and special conditions.

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

If more than 30 days have elapsed since the renewal date, a new Application Form shall be issued for the Insured as if they were a new applicant, and the Insured shall be admitted to insurance as a new Insured. Acquired rights and any previously granted Lifetime Renewal Guarantee shall not be valid, and a risk assessment shall be conducted for existing conditions. Any discounts obtained under the previous policy (including those arising from the claim/premium ratio) shall not remain valid.

The Insurer reserves the right not to provide coverage for risks occurring during the period until the issuance of the new policy, to provide coverage subject to conditional acceptances (such as limits, Risk Additional Premium, co-payment, waiting periods, etc.) in accordance with the Risk Acceptance Regulation, and to revoke renewal rights.

The Insured must comply with the duty of disclosure during renewal as set forth in Article 6 of the General Conditions of Health Insurance and Article 1435 of the Turkish Commercial Code.

## J - SAGMER (INSURANCE INFORMATION AND MONITORING CENTER) DISCLOSURE

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

## K - PAYMENT OF INDEMNITIES

**1.** Beneficiaries are obliged to submit the relevant documents to the Insurer in order to claim their rights arising from the policy. The documents required for indemnity payments may vary depending on the coverages under the policy and the nature of the claim. Explanations regarding the information and documents required for claims submitted to non-contracted institutions can be found in 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 Services Center at +90 850 755 0 755.

**3.** Indemnity payments shall be evaluated within the scope of the policy's special and general conditions, any applicable additional protocols, and the coverage limits specified in your policy.

**4.** For provision procedures at our contracted institutions, your Turkish Identification Number is sufficient.

**5.** Upon the occurrence of the risk, the obligation to pay indemnity rests with the insurance company.

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## L - OTHER INFORMATION

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

## M - COMPLAINTS AND REQUESTS FOR INFORMATION

**1.** In addition to the verbal information provided to you regarding the characteristics of insurance transactions carried out or to be carried out in relation to technical matters concerning insurance, both during the negotiation and conclusion of the insurance contract and throughout the validity period of the contract, as well as regarding the insurance coverage subject to the contract and the operation of the insurance, you may also submit any requests for information and complaints related to the insurance to the addresses and telephone numbers provided below.

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

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Large Taxpayers Tax Office: 879 001 8869 Registry No: 38676