UNİSAĞLIK-HEALTH INSURANCE POLICY FOR FOREIGNERS SPECIAL CONDITIONS

These special conditions are valid for foreign citizens (non-T.R. citizens) having the Unisağlık-Health Insurance Policy for Foreigners and they cover the minimum coverage defined in the Circular on the Private Health Insurances for Residential Permit Requests dated 06/06/2014 and numbered 9, and the Circular on the Private Health Insurances for Visa and Residential Permit Requests dated 10.05.2016 and numbered 16.

Article 1 SUBJECT, DURATION AND SCOPE OF INSURANCE

In addition to the General Conditions of Health Insurance,UnicoSigorta A.Ş.herebyshall cover the health expenses required for inpatient and/or outpatient treatment incurred in the health care providers contracted specific to this product, in the event of any illness and/or accident within the insurance period of the insured, considering the coverage, limit, payment percentage and waiting period, in accordance with the special and general conditions.

Insurance agreement is the agreement between the insurer and insurant consisting of the application and information of the insurer and insured, general health insurance conditions, special conditions (limits, exceptions and special exceptions, etc.), policy, coverage table and the supplements of thereof (therefore to be named as the Insurance Agreement).

With this agreement, a health insurance policy can be issued only for foreigners (non-T.R. citizens) and such people can be included within insurance coverage (therefore to be called as the insurant/insured).

Health insurances are issued for 1 (one) year. They cover the time between the start and end dates of the policy. The policy becomes valid at 12.00 PM Turkey time and expires at 12.00 PM on the termination date. Insurance period cannot exceed one year. All changes and additions to be done within the validity period of the Insurance Agreement are valid unless requested in a written form and mutually agreed on. Changes or additions that aren't notified as accepted by the insurer in a written form are invalid.

Liability of the insurer begins after the issuance of the policy, provided that the entire insurance premium is paid in the case of cash payment, and the advance payment is paid in case the payment is installed.

The insurance policy issued under the conditions agreed by Unico Sigorta (therefore to be called as the Insurer under these special conditions) and insured/insurant consists of the application and information form filled and signed by the insurer/insured, the General and Special Conditions of Health Insurance, which are the inseparable parts of the policy, and the list of contracted insurance providers.

The insured is deemed to have given permission to the Insurer to get information about the insured's medical history and current situation, get and submit all kinds of information to institutions, physicians and 3rd parties about his/her treatment, request records from these and for on-site monitoring from the

moment when the application and information form for the insurance coverage is filled and signed throughout the policy period when considered as necessary by the Insurer.

Insurance coverage is valid only for the people included in the insurance policy, and people excluded from the policy cannot benefit from the coverage.

Coverage including the daily fee for incapacity to work due to the lost gains arising from the inability to work because of disease, and care costs or daily care costs when the insured is in need for care aren't included in the policy.

Policy special conditions may be changed (coverage, insurance cover and limits, premium, waiting period and exceptions) by the insurer. These changes shall be valid as of commencement date of the repeated policy for each insured.

Article 2 DEFINITIONS

POLICY
Written document of the insurance policy signed between the insurer and the insurant that includes definitive information about the insured person(s), start and end dates of insurance, premiums to be paid and the coverage amounts.

POLICY START DATE
This is the date when the coverage in the insurance agreement is in effect for the first time or successive times. The policy takes effect at 12.00 PM Turkey time on the date indicated.

POLICY END DATE
This is the date when the coverage on the insurance agreement is terminated. The policy expires at 12.00 PM Turkey time on the date indicated.

POLICY ISSUE DATE
This is the date when the policy is issued upon the application / renewal form filled by the insured.

POLICY SPECIAL CONDITIONS
These are the product-specific conditions that are prepared by the insurer as an inseparable part of the policy and don't contain provisions against the insurant / insured as mentioned in the General Health Insurance Conditions and Private Health Insurance Regulation.

HEALTH INSURANCE GENERAL CONDITIONS
These are written rules defined by the Prime Ministry, Undersecreteriat of Treasury and used by all insurance companies in health insurances. The most up-to-date General Conditions can be found at www.tsb.org.tr web site.

NEW BUSINESS
Policies issued without detailed risk assessment are considered as New Business and this is indicated on the policy. In the policies issued as new business, the waiting period specified in the special conditions is applied.

RENEWAL

Upon the request of the insured and as a result of the comprehensive risk assessment, the policies approved by the insurer are regarded as renewals and this is indicated on the policy. The waiting period is not applied in the policies that the insurer accepts as renewal.

WAITING PERIOD
It is the period determined by the insurer in order that the diseases mentioned in the special conditions are covered by the scope of the coverage and requiring to pass as from the policy start date. The waiting period shall continue to be applied from the commence date of the policies issued as new business, but if it is deemed appropriate by the insurer, in the cases where the insurance is issued by carrying out a comprehensive risk assessment as a renewal and this is indicated on the policy, it shall be removed in the conditions determined by the insurer.

APPLICATION AND INFORMATION FORM
The form, which should be signed by the insurant/insured and containing information provided by the insurer in order to prevent possible lacking information about the agreement's subject, coverage and other specifications during the discussion and issuance of the agreement, and to ensure that the related parties are informed about the possible changes and developments related to the execution of the agreement that may affect the insurant, insured and arise during the course of agreement, is called the Application and Information Form. This form serves as an offer for the insurer. Filling out this form does not mean that the agreement relationship has started; the policy is issued unless the form is accepted after the evaluation of the insurer and when the premium (or the advance payment) is paid.

INSURANT
Real or legal person who is a party to the insurance agreement along with the insurer, and undertakes the obligations arising from the insurance consisting of the payment of insurance premiums.

INSURER
The institution that undertakes to pay compensation to the insurant/insured in return for the premium paid by the insurant in case the risk occurs.

INSURED PARTY/PARTIES
Person(s) whose names are written on the policy covering the health costs with the insurance agreement.

COMPANY
İMECE DESTEK DANIŞMANLIK HİZMETLERİ A.Ş. (İMECE SUPPORT CONSULTING SERVICES INC.), which makes contracts with the contracted Health Providers and ensures that the insured parties of the Insurance Companies receive the healthcare services from the Contracted Service Providers in accordance with the contents of the product they bought in return for the agreements they sign.

CONTRACTED INSURANCE PROVIDER
These are healthcare service providers having a special agreement with the COMPANY and providing healthcare services to the Insurance Company insured within the scope of such agreement.
List of Contracted Health Insurance Providers for Foreigners (YSS) is available at www.unicosigorta.com.tr web page owned by UNICO SİGORTA A.Ş. and İMECE DESTEK DANIŞMANLIK HİZ. A.Ş. www.imecedestek.com address with its up-to-date version. The insurance company reserves the right to make changes in the list of Contracted Insurance Providers.

NON-CONTRACTED INSURANCE PROVIDER
Healthcare institutions that don't have a special agreement with the COMPANY and are not included in the list of Contracted Insurance Providers.

SAGMER
Insurance Information and Supervision Center, was established with the name "TRAMER" with the Traffic Insurance Information Center Directive prepared by the Undersecreteriat of Treasury and published in the Official Gazette dated 16.12.2003 and numbered 25318. With the directive published on 9 August 2008 in the Official Gazette numbered 26962, its name was accepted as the Insurance Information Center, and its name was changed into Insurance Information and Supervision Center with the directive amendment published in the Official Gazette dated 03.11.2011 and numbered 28131.
SBM (Insurance Information and Supervision Center) was established as an institution possessing a legal identity where the data regarding Life, Illness/Health, Compulsory Traffic, Green Card, Compulsory Road Transportation Financial Liability, Compulsory Bus Seat Personal Accident, Motor Land Vehicles-Automobile Insurance, Medical Injury Compulsory Financial Liability Insurance, Hazardous Materials and Bottled Gas Compulsory Liability Insurance, Professional Liability Insurance are collected at one centre, aiming to execute insurance activities in a more comprehensive and effective manner, ensure practice uniformity across the sector and healthy pricing, prevent misuse, create reliable statistics, increase trust in the insurance system and activate public supervision.

PREMIUM
This is the price charged from the insurant by the insurer in order to pay compensation within the coverage it commits to provide for the insured.

PARTICIPATION PRACTICE
This is the participation/undertaking of the insured to each expense within the coverage in the ratio as mentioned in the coverage table.

COVERAGE LIMIT
Coverage limit stated in the policy for the coverage without insured participation is equal to the maximum compensation amount to be paid. This is the amount remaining after the insured's participation share is deducted from the maximum compensation amount to be paid for the coverage with insured's participation.

PREVIOUSLY EXISTING DISORDERS
These are the disorders/diseases previously existing before the insurance. These are the disorders and their recurrences and complications of which the start and development process of their symptoms/findings or diagnosis/treatment is dated before the insurance commence date.

COMPLICATION
This is a health situation related to a disease during or after the course, treatment of such disease.

PROVISION APPROVAL
This is the payment commitment of the Company for the health expenses in favour of the insured within the principles mentioned in policy special conditions.

CONGENITAL DISEASE
These are diseases, anomalies or physical (organ) disorders present since the person's birth. In some cases, the complaints may appear in later ages.

CHRONIC DISEASE
These are diseases which cannot be cured totally or require long-term monitoring and treatment.

BECOME DUE
The premium and/or the compensation become claimable.

EXEMPTION
This is the part of healthcare expenses undertaken by the insured that will not be afforded by the insurer. Exemption amount can be the starting period of the coverage and/or the coverage percentage and is valid for all insured within the plan.

RISK/HAZARD
For health insurance beneficiaries, risk means the physical conditions, habits, etc. that may increase the possibility of diseases and accidents.

RECOURSE
This is the right of the insurer to demand the treatment costs it paid from the third parties that have responsibility in the formation of treatment costs in terms of succession.

COVERAGE
This is the assurance committed by the insurer for the insured within the special and general conditions of the insurance policy in case the risk occurs.

WAITING PERIOD
This is the time defined by the insurer for the diseases mentioned in the policy special conditions to be included in the coverage, and which needs to pass after the insurance commence date.

ACCIDENT
This is when the insured is under a physical effect will due to a sudden and external event without insured's own.

TURKISH MEDICAL ASSOCIATION (TTB) MINIMUM PRICING TARIFF
This is the tariff announced by the Turkish Medical Association Central Committee regarding the minimum physician fees to be applied in healthcare services. Pricing is calculated by adding VAT to the multiplication of the units mentioned in the tariff with related provincial service coefficient.

OBLIGATION TO NOTIFY
This is the necessity of the insurant/insured to state all present diseases and matters of the insured candidate that may affect the evaluation of the risk in full and in a written form during the insurance agreement application.

COMPENSATION

In case the health risk occurs within the insurance agreement, this is the amount to be paid for the healthcare expenses by the insurer within the coverage mentioned in the policy, Health Insurance General and Special Conditions and Regulation for Private Health Insurances.

SUPPLEMENTARY POLICY
This is the additional insurance agreement issued as supplementary to the policy with the same legal authority after the policy takes effect that includes the changes in the matters mentioned in the policy.

TAX DEDUCTION
In accordance with articles 63 and 89 of the Income Tax Law numbered 193 that were changed with the Law numbered 3239 which took effect on 01 January 1986, the premiums to be paid by the taxpayer for the Insurance and Personal Accident Insurance for his/her spouse and minor children are included in tax deductions.
These articles defining the rules and limits for the tax deduction were changed with the Law numbered 6327 published on the Official Gazette dated 29 June 2012 and numbered 28338, and new regulations took effect after 01 January 2013.
Health and Personal Injury Insurance premium to be paid by the permanent employed taxpayer can be deducted from the income tax basis provided that it doesn't exceed 15% of the monthly gross income earned in the month when the premium is paid and the minimum monthly fee. The Health and Personal Injury Insurance Premium to be paid by the taxpayer who is subject to the income tax statement (provided that the premium is paid within the year when the income was earned and the price isn't also deducted during the calculation of the net income of the person(s)) can be deducted from the income tax basis in a way not to exceed the 15% of the annual income stated and the annual minimum fee amount.
In order to benefit from this law, 1) you need to submit the Health and Personal Injury Insurance receipt to the Accounting Department of the company you work at if you're a permanent employee, 2) if you are self-employed, you need to state the premium amount on the Health and Personal Injury Insurance receipt in the income tax statement. (Bank receipts, automated teller machine receipts and credit card receipts can be accepted provided that they include information such as the name and surname of the premium payer, the period of the payment, premium paid, title of the insurance company where the payment was made to and payment amount.)

Article 3 COVERAGE SCOPE

This policy hereby covers the minimum coverage defined in the Circular on the Private Health Insurances for Residential Permit Requests dated 06/06/2014 and numbered 9, and the Circular on the Private Health Insurances for Visa and Residential Permit Requests dated 10.05.2016 and numbered 16.

The Health Insurance Contract covers the payment of the treatment costs that policy holder insured may incur while receiving health service from the contracted health care providers which have an agreement/protocol with the COMPANY considering policy coverage, limit, participation rate, waiting period, etc. in accordance with the special and general conditions, in the light of the contract that the insurer has executed with the COMPANY.

However, in cases when the inpatient treatment of the insured continues on the date of policy termination, all related expenses are within the coverage scope for 10 days after the policy termination

within the special and general policy conditions. In cases when the policy coverage limit and payment ratio are exceeded, the insurance company does not make payments.

The COMPANY reserves the right to make changes on the Contracted insurance providers valid for this policy (adding new providers or cancelling the agreement with the institution) is reserved. You can find the up-to-date version of the **List of Contracted Insurance Providers of Health Insurance for Foreigners (YSS)** on www.unisigorta.com.tr and İMECE DESTEK DANIŞMANLIK HİZ. Corp. www.imecedestek.com.

COVERAGE NAME		COVERAGE AMOUNT		INSURED PARTICIPATION RATIO	
INPATIENT CARE COVERAGE	COVERAGE TYPE	Contracted Insurance Provider	Non-Contracted Insurance Provider	Contracted Insurance Provider	Non-Contracted Insurance Provider
Internal Inpatient Care	ANNUAL	UNLIMITED	20,000 (TRY)	0%	20%
Surgical Inpatient Care (Surgery)					
Operator Physician					
Room, Food, Accompaniment (180 days a year)					
Chemotherapy/Radiotherapy/Dialysis					
Intensive Care (90 days)					
Home Care (45 days)					
Small Interventions					
Ground Ambulance					
Artificial Limb	ANNUAL	10,000 (TRY)	10,000 (TRY)	0%	20%
OUTPATIENT CARE COVERAGE	COVERAGE TYPE	Contracted Insurance Provider	Non-Contracted Insurance Provider	Contracted Insurance Provider	Non-Contracted Insurance Provider
Physician Examination	ANNUAL	2,000 (TRY)	2,000 (TRY)	40%	40%
Medicine					
Imaging and Laboratory Services					
Modern Diagnosis Methods					
Physical Therapy Coverage (15 sessions a year)					
Supplementary Medical Material	ANNUAL	500 (TRY)	500 (TRY)	40%	40%

Article 3.1. INPATIENT CARE COVERAGE

Inpatient care coverage affords the medical and/or surgical admissions related to the diseases and disorders occurring after the insurance commence date, emergency healthcare costs of the insured that may cause a vital hazard, small interventions within the coverage, limit and participation ratios in accordance with the special and general conditions provided that these are medically necessary and the physician states the reasons in his/her report in detail.

In case the insured has inpatient care at the hospital, daily room rate (limited to standard single bed room rate), food, companion, physician, medicine, operating room, operator anaesthetist, nurse (limited to standard nurse service fee), intensive care, all kinds of consumable costs, chemotherapy (including the medicine with "interferon and peg interferon alpha" active substances used in Hepatitis C treatment), radiotherapy, dialysis (within the annual limit stated in the policy), extracorporeal shock wave lithotripsy

(ESWL), morgue costs in case the insured dies during therapy, mandatory prostheses used during the operation (cardiac valve, pacemaker, hip prosthesis, etc.) are evaluated within this coverage and afforded within the coverage limit and participation ratios mentioned in the coverage table in accordance with the special and general conditions.
Intensive care inpatient care period is limited to 90 days unless otherwise stated and evaluated within 180-day-long inpatient period.

Provision approvals obtained for treatments to be performed at contracted healthcare providers are valid unless they are performed within 7 days. Regarding processes that don't take place within this period, a new provision should be obtained. Regarding the processes that aren't performed within 7 days and for which a new provision approval isn't obtained, the insurer reserves the right to refuse.

In all admissions with provision approval and performed, in order for the costs related to the matter after the 10th day to be paid, an approval should be obtained from the insurer again on the 11th day.

Even though the emergency health status causing the insured to apply at the hospital is made at the emergency departments of healthcare institutions, diagnosis, examination and first diagnosis costs are evaluated within outpatient therapy coverage and this is included within the coverage with the insurer's participation ratio as 60%.

Costs related to ectopic pregnancy and hydatidiform mole are considered within the inpatient treatment coverage.

In operations performed in same or separate cuts, the Operator, Anaesthetist, Assistant and Anaesthesia fees are applied within the TTB general rules and principles at the policy coverage and limit ratios.

Also, at non-contracted institutions, operation room opening fee is limited to the 30% of the operator fee.
In cases when the treatment requires more than one surgery, payment is made within one surgery limit.
In case more than one surgery is made under the anaesthesia (with the same cut) and if all of these aren't included within the insurance coverage, operator fee is paid based on the number of operations covered.
In case more than one surgery is performed under the anaesthesia (separate or same cut) Articles 3 and 4 of the principles announced by TTB are valid. In case there are re-treatments due to incorrect diagnosis and treatment, the institutions or physicians causing this are responsible.

Even though necessities subject to the Operation Costs coverage that may occur after discharge from hospital are valid for the same disease, they will be considered as a separate surgery.

Whether declared or not, all kinds of healthcare costs related to disorders/diseases present before the policy commence date including the recurrence and complications of these diseases (whether diagnosed or not) are outside the scope of this insurance and not paid.

Operator Physician Fee

Inpatient treatment costs at the contracted healthcare institutions where the insurance policy is valid are paid within the coverage, limit and participation ratios in accordance with the special and general conditions stated in the policy.

Physician's fee in case the treatment is performed by non-contracted (not among the staff) physicians no matter if the treatment is at a contracted or non-contracted institution, is limited to 1 TTB (as stated in the Turkish Medical Association Minimum Price Tariff).

If the physician performing the treatment is not the permanent or temporary employee of the contracted institution (anaesthesia and assistant physicians are included), treatment fee will be paid by the insured under any circumstances and then sent to the insurer for evaluation.

Contracted physician fee is paid within the limit and participation ratios stated in the policy and in accordance with special and general conditions. Regarding the physician fees of the processes not mentioned in the TTB Minimum Price Tariff or disputed processes, TTB's opinion is taken.

Small Intervention Coverage

Small interventions up to 149 units (including 149 units) and stated in the Minimum Price Tariff announced by Turkish Medical Association (TTB), dressing, injection, serum attachment, ear wash, all kinds of plasters (including the ones above 149 units), oxygen supply, apse drainage, gastric lavage, clyster, catheter placement, nail removal, all kinds of cauterization, probe curettage, fractional curettage and dilated curettage even if practiced for treatment purposes, in-joint injection application, and all small interventions with local or general anaesthesia such as the removal of benign skin tumors of all sizes and quantities are paid from this coverage within the coverage, limit and participation ratios stated in the policy coverage table in accordance with the special and general conditions provided that the physician's report showing that the treatment is necessary and they are approved by the company.

Home Care

If the physician treating the insured finds as necessary and the insurer approves, home care treatment plan of the insured and occurring costs are paid from this coverage within the coverage, limit and participation ratios stated in the certificate in accordance with special and general conditions as limited with 45 days unless otherwise stated. In order for the insured to benefit from the home care coverage, s/he should have tracheotomy, frequent need for orotracheal aspiration, enteral nutrition needs, TPN/IV fluid support need, dependence on the ventilator and respiratory insufficiency, and protocol for advanced level oncology patients and pain should be practiced.

Artificial Limb/Prostheses

Support prostheses, artificial limbs (eye, hand, arm, leg) costs, which are mandatory to be used as documented by the physician within 30 days after an operation and/or accident that occurs after the insurance commence date, and approved by the company, and treatment costs by dentists related to dental/maxillofacial surgery due to accidents (provided that the accident report prepared by official authorities is submitted) are paid from this coverage and deducted from Inpatient Care Coverage limit within the coverage, limit and participation ratios stated in the policy coverage table in accordance with the special and general conditions.

Ambulance

In case the insured has to be transported to the closest general hospital from his/her location due to a disease or accident within the coverage and borders of Turkish Republic, from hospital to home, from home to hospital with a contracted ambulance or a locally licensed land ambulance if no contracted ambulance is present, and/or from his/her city and hospital to another city and hospital with a land ambulance if the treater physician finds mandatory and the company approves, occurring costs are paid within the related coverage, limit and payment ratios in accordance with special and general conditions. In case of using non-contracted local ambulance, coverage is limited with the fee of valid contracted land ambulance for the same distance.

Regarding ambulance services, emergency situations mentioned in Special Conditions Article 8 are based on.

ARTICLE 3.2. OUTPATIENT CARE COVERAGE

Physician examination, analysis/x-ray, prescribed medicine, modern treatment methods and session outpatient treatment costs related to the disorders occurring after the insurance commence date are considered within outpatient treatment scope.

In cases with outpatient coverage, treatment costs are paid from this coverage within the limits and participation ratios stated in the policy and in accordance with the special and general conditions. Treatment costs exceeding the upper outpatient limit in the policies aren't refunded. Outpatient coverage cannot be granted individually, they are provided only along with inpatient treatment coverage.

Whether declared or not, all kinds of healthcare costs related to disorders/diseases present before the policy commence date including the recurrence and complications of these diseases (whether diagnosed or not) are outside the scope of this insurance and not paid.

Physician Examination

Physician examination costs within the outpatient care to be performed by physicians working at hospitals and clinics with working licenses issued by T.R. Ministry of Health or authorized to open private doctor's office, which are documented with the Health Insurance Patient Information Form, are paid within the limit, participation ratio, exceptions stated in the policy and in accordance with the special and general conditions. Examinations up to 10th day related to the diagnosis in the initial examination are follow-up examinations, and treatment costs invoiced under such titles aren't paid.

Costs of examinations by physicians not working as permanent/temporary employees at contracted institutions will be paid by the insured under any circumstances and sent to the insurer for evaluation.

Prescribed Medicine

Costs related to medicines approved by T.R. Ministry of Health will not be paid without the original prescription, medicine label, invoice and/or bill.

Our dosage limitation practice during medicine purchase is valid for 1 month-long-dosage. However, the medicines should be bought within 15 days after being prescribed. Except for chronic medicine usages, medicines bought after 15 days will not be paid by the insurer.

During long-term medicine treatments, 1-month-long dosage is paid with the same prescription each time in accordance with the limit and participation ratio stated in the policy and special and general conditions.

Analysis-X-ray

Analyses, x-ray expenses for situations within the coverage where the medical doctor finds medically necessary for the diagnosis and treatment, and which are mentioned in the Health Insurance Patient Information Form and occur during the validity period of the policy and medicine, anaesthesia and physician fees required by such diagnosis methods are paid within the limit, participation ratios and in accordance with special and general conditions.

For diagnosis processes, Health Insurance Patient Information Form should be completely filled by the Physician and each diagnosis process that is considered as necessary by the Physician should be stated in this form. Analyses to be done till the disease of the insured is diagnosed are considered as a usage right.

Advanced Diagnosis Methods

Tomography, scintigraphy, MR, nuclear medicine and scintigraphies (thallium, etc.), endoscopic procedures (gastroscopy, colonoscopy, cystoscopy, bronchoscopy, mediastinoscopy, etc.), EEG, EMG, angiographies (except for coronary angiogaphy), biopsies (including biopsy costs for endoscopic costs, only liver biopsy excluded), hearing test costs that are found as medically necessary for diagnosis and treatment by the medical doctor and stated in the Health Insurance Patient Information Form, and the medicine, anaesthesia and physician costs required by these diagnosis methods are paid within the limit and participation ratio stated in the policy in accordance with the special and general conditions.

For diagnosis processes, Health Insurance Patient Information Form should be completely filled by the physician and each diagnosis process that is considered as necessary by the physician should be stated in this form.

Supplementary Medical Material

Mobile and custom medical materials such as splints (orthesis, brace, active ankle, bone spur pad), walker, elastic bandage, slings, corsets, varsity sock, neck brace, knee piece, wrist supporter, sitting piece, crutches that support the body externally and are used for medical purposes as a part of the treatment applied on the insured as a result of an accident and disease which occurs after the insurance commence date, dressing materials used in burns or wound treatments are paid from this coverage to be deducted from the Outpatient Care Coverage limit within the coverage, limit and participation ratios in accordance with the special and general conditions stated in the policy coverage table.

Physical Treatment and Rehabilitation (Session Outpatient Care Processes)

Physical Treatment and Rehabilitation (Puva, phototherapy, hyperbaric O2, ESWT, etc.) costs that are decided as necessary by the physician for the treatment of a disorder within the coverage and approved by the insurer as session / day are paid in accordance with the limit, participation ratio and special and general conditions stated in the policy. Annual limit is 15 sessions.

Article 4 GEOGRAPHICAL SCOPE

This insurance is valid at insurer's Contracted Insurance Providers within the borders of Turkish Republic and within the health Insurance General Conditions and policy special conditions and limits. Abroad treatment costs (including TRNC) aren't within the coverage of this policy.

ARTICLE 5 STANDARD EXCEPTIONS

Situations below and all complications resulting from such situations other than the Non-Coverage situations as mentioned in Article 2 and 3 of Health Insurance General Conditions are excluded from all coverages from this Policy.

1. Whether declared or not, all kinds of healthcare costs related to disorders/diseases present before the policy commence date including the recurrence and complications of these diseases (whether diagnosed or not),
2. Congenital anomalies and diseases, genetic diseases, even if they show up at advanced ages and defined after the policy commence date, premature baby and incubator costs unless a contrary agreement is issued (even if the baby was insured from birth), cord cysts in children below 7, hydrocele, all kinds of hernia costs,
3. Scoliosis, kyphosis, lordosis, pes planus, hallux valgus/rigidus analysis and treatment costs,
4. Treatments for nasal septum deviation and concha hypertrophy, diagnosis, treatment and supplementary device costs for sleep apnea, sleeping disorders and snoring disorders
5. Dementia, Alzheimer, Parkinson, Epilepsy and antipsychotic, anxiolytic, anticonvulsant and all psychotrophic medicines used in the treatment of these diseases
6. All kinds of genetic disease/situation researches, analyses for scanning, structural defects, motor mental development and growth disorders,
7. Mental disorders and psychological disorders requiring psychiatry services and costs of pedagogue, social care professionals, etc.
8. Treatment for alcoholism, alcohol, tranquilizer, stimulant, hallucinogen, etc. addiction and all kinds of substance addiction and all costs resulting from the disorders, accidents related to use of such and all treatment costs related to unlicensed vehicle driving
9. Healthcare costs related to all dangerous/safe professional (licensed), amateur or recreational sport activities and/or all competitions and dangerous activities that aren't limited to these (mountain climbing, diving with respiratory equipment, aircraft and glider piloting, parachuting, parapant, hanggliding, horseback riding, skiing, water sports, diving, using atv and motorcycles even if for transportation purposes, etc.)
10. Costs related to alternative treatment methods (acupuncture, homeopathy, hypnosis, yoga, mesotherapy, ayurveda, thermal spring and mineral springs, etc.) and treatments at centres working without the license of Ministry of Health, sanatorium, preventorium and rehabilitation centres, treatments not scientifically approved, experimental treatments and treatments that are accepted to be in the experimental state by the US FDA (Food and Drug Administration), processes/treatments not included in TTBAUT (Turkish Medical Association Minimum Price Tariff), weight loss and weight gain programs or treatments related to appetite disorders,
11. Robot usage fee in operations with Robotic Surgery method (Da Vinci) and all kinds of material costs used within this method. Costs related to new biomedical engineering, genetic and biotechnological treatments and practices,
12. Examinations with diagnosis purposes, treatment and examination costs, all prescribed medicine and materials required by non-medical doctors or centres without the operation license of the Ministry of Health and the first degree relatives of the insured or with invoices requested by these, invoices issued

by the first degree relatives of the insured, healthcare costs of the physicians whose expertise area does not match the insured's disease
13. Unnecessary inpatient treatment costs stated in the definitions section and costs of diagnosis and treatments not related to a specific complaint/disease and the particular complaint (Check-up, routine checks, etc.),
14. Unless not occurring within the validity period of the policy as a result of a judiciary accident; plastic and reconstructive surgery, all kinds of aesthetic and cosmetic interventions, telangiectasis, treatments for skin hemangioma, gynecomasty, analysis and treatment processes to prevent sweating, analysis and treatment costs related to acne and hair loss (shampoo, skin creams, soaps and similar cosmetics included), iontophoresis, Botox processes
15. Hearing impairment treatments (tube installation, tympanoplasty, stapedoctomy, chronic otitis sequel, etc. excluded) and all analyses and treatments related to these,
16. Laser and surgical practice costs related to refraction disorders, keratoconus, cross-eyes, diplopia and eye refraction disorders and all kinds of analysis, diagnosis and treatment costs related to lazy eye and multifocal lenses
17. All kinds of intervention, diagnosis and treatment costs for teeth, gums and jaw, tooth prostheses (costs for the recovery of jaw and teeth which are damaged as a result of a traffic accident that the insured may encounter after the insurance commence date are excluded) and all kinds of orthodontia and teeth treatments with aesthetic purposes
18. Materials not accepted as medicine, all kinds of substances and chemicals licensed by the Ministry of Agriculture, all medicine and external prostheses and support prostheses not officially imported (the ones not included within the Inpatient Care Coverage), vitamin and mineral combinations and/or nutrition regulating preparations that are used to provide the daily needs of the body and/or protect general health situation, moisturizers used at home, medicines externally attached to the body, injectors not taken with medicines, bands, glasses-glass-frame-lens solutions, wheel chair, hearing aids, orthopaedic boot-soles-slippers-shoe costs, toothpaste, mouth and teeth care preparations, etc.), costs related to phone, TV, cafeteria, administrative service paramedical services and service fees which aren't necessary for the treatment, baby diapers, baby food and feeding bottle, teat, baby care creams, etc. similar costs
19. Costs related to all kinds of analyses and treatments for vaccines causing allergy, allergy tests, all kinds of immunotherapies (the ones for the treatment of metabolic and autoimmune diseases are excluded),
20. Routine checks and costs related to pregnancy, miscarriage, abortion (even if mandatory), birth (normal/cesarean), birth control methods, family planning miscarriage research test-tube baby, penile prosthesis, infertility, (follicle monitoring, hysterosal pingography, spermiogram, adhesiolysis tobuplasty, etc.), sexual dysfunction, varicosele whether related to infertility or not, sexual change operations, sexually transmitted diseases (syphilis, gonorrhea chancroid, lymphogranuloma venerum, granuloma inguinale diseases, genital condylomas, etc.), AIDS and all analyses and treatment costs related to these, all costs related circumcision even if medically necessary, voice and speaking therapy
21. Varicosity and vein thrombosis treatment (sclerotherapy, laser, beam, massage, socks, etc.),
22. Costs related to providing donor, organ and blood transfer,
23. Officially announced epidemic illnesses or epidemic illnesses initialized with bad intentions
24. Healthcare costs resulting from the errors in the diagnosis, treatment or all kinds of surgical interventions practiced by healthcare institutions or physicians
25. Private nurse costs not approved by the company, ambulance costs other than the emergency situations mentioned in Article 8 of Special Conditions, all kinds of air and sea ambulance costs

26. All vaccines for rabies, tetanus, flu in case of contagion and vaccinations other than the vaccine calendar of the Ministry of Health for children between 0 and 6 (analysis and vaccination costs before or after the vaccination are included),
27. All inpatient, outpatient and/or emergency healthcare and treatment costs abroad including the Turkish Republic of Northern Cyprus
28. Coverage including the daily fee for incapacity to work due to the lost gains arising from the inability to work because of disease, and care costs or daily care costs when the insured is in need for care isn't included in the policy.
29. Regardless of any reason, all kinds of Bariatric Surgery methods (gastric bypass, stomach balloon, stomach tube, stomach staple, stomach reduction surgeries, biliopancreatic diversion, jejunoileostomy, bowel reduction, etc.)

ARTICLE 6 SITUATIONS WITH WAITING PERIODS

In the policies issued as new business; apart from the first examination fee, all outpatient diagnosis/prognosis, outpatient treatment, small intervention, surgical therapy and inpatient diagnosis and treatments for the diseases and complications written below are out of the coverage of the insurance during 12-months from the policy commencement date.

Situations with 12-Month-Long Waiting Period

All kinds of organ transplantation (except for a result of accidents) and their complications, all kinds of skin related processes such as tumor, lipoma, verrucose, nevus, etc., cyst (skin, subcutaneous, kidney, vaginal, etc.), removal of polyps and nodules, anorectal diseases (hemorrhoid, fissure, fistula, pilonidal sinus, etc.), GIS hemorrhages, diseases related to diverticulum, sphincterotomy, all kinds of hernia, spine and disc disorders (disc hernia, facet denervation, nerve blockage, etc.), hygroma, trigger finger, joint disorders (meniscus, connective tissue lesions, connective tissue disorders in shoulder, elbow, ankle joints, etc.), uterus-ovary and tube diseases and surgeries, bartholinitis cyst, endometriosis, cystorectocele, dialysis, kidney and urinary tract operations and stones (ESWL), bladder disorders, hydrocele, breast disorders and operations, sinusitis and sinus surgery, tonsillar, adenoid, hearing surgery (tympanoplasty, tube placement in ear, stapedectomy, etc.), cataract, glaucoma, keratoplasty, prostate (including TUR), varicosity, paralysis, thyroid and parathyroid gland diseases, gall bladder, gallstones and bile duct diseases, liver diseases, liver biopsy, cyst hydatid, surgical interventions related to pancreas and spleen diseases (except for the ones resulting from accidents), cardiovascular diseases (coronary angiography, bypass, angioplasty, aort dissection, aneurysms included), all kinds of chronic diseases [hypertension, ulcer, inflammatory bowel diseases (ulcerative colitis, crohn), COLD, asthma, diabetes, epilepsy, multiple sclerosis, hepatitis B, sarcoidosis, nephrite, all rheumatismal diseases, connective tissue diseases, etc.] invasive interventions for diagnosis and treatment (angio, ERCP, etc.), arthroscopic, endoscopic and laparoscopic interventions, dialysis, chemotherapy, radiotherapy and costs for cancer treatment

ARTICLE 7 COMPENSATION EVALUATION AND PAYMENT PROCESSES

Insurant/Insured has to inform the insurer about the disease and treatment, and avoid providing misguiding information. Even though a payment guarantee is given to the contracted institution or the compensation is paid by the insurer based on lacking or wrong information, if it is determined that such disorder of the treatment is excluded from the coverage both during the treatment and the later stages of the treatment, the compensation paid by the insurer may be requested to be refunded.

Regarding the situations requiring a planned admission and/or surgery other than the emergency situations, insured's situation minimum 48 hours before the admission and the provision approval form filled by the physician to perform the surgery should be submitted to the Provision Center. After the insurance company makes the necessary examination, it will give feedback on whether the admission and/or surgery costs will be paid within the policy coverage or not.

Insured's treatment costs at the contracted provider within the inpatient and outpatient care coverage are directly paid to the contracted insurance provider within the limit, participation ratio, special and general conditions stated in the policy.

Whether emergency or not, all Compensation and Provision processes at the Contracted Institutions related to the treatment expenses within your policy will be provided by İMECE DESTEK PROVİZYON MERKEZİ.

For your 7/24 Compensation and Provision services, you can call the Provision centre at 0212 978 14 51.

Other than the ones paid at the contracted insurance providers, payments made by the insured at the non-contracted insurance providers are paid within the limit, participation ratio, special and general conditions stated in the policy in case the original invoices showing the healthcare expenses are submitted to the insurer.

Insured's disorder and analyses and treatment processes performed should be documented by the physician's report. Insurer may request the necessary documents for review during the compensation evaluation from the insurant/insured. Insurer informs the costs outside the coverage to the insured with a letter explaining the reasons for refusal.

In case the inpatient care treatment of the insured is performed at a contracted insurance provider by a non-contracted physician, the insurer doesn't guarantee the direct payment for the physician's fee. Maximum amount that can be paid by the insurer to the insurant / insured for the non-contracted physician's fee is limited to the process' equivalent stated in the Turkish Medical Association Minimum Price Tariff. (1TTB) In case the treating physician is contracted, physician fee payment is done within the limit, participation ratio, special and general conditions stated in the policy.

After all kinds of healthcare treatment, you should see your invoice and check for costs on your behalf, especially the hospital discharge invoices after all hospital admissions should be reviewed and signed.

In policies where the insurance premium is paid in instalments, remaining instalments become due and they are deducted from the compensation to be paid to the insured.

After a risk within the coverage occurs and the compensation is paid to the insured (beneficiary), the insurer has the right to demand the loss from the person or establishment causing the loss in place of the insured per the "succession principle" in the related regulation. In order to execute this right, the insured is obliged to provide all kinds of information, document and support for the insurer. (Transfer of Right Principle)

In order for the payments under the inpatient coverage to be made, following documents should be submitted to the insurer and/or company.

1. Hospital invoices with breakdown signed by the insured, report showing the reason for admission,
2. Detailed surgery report in case of surgical interventions (if a piece is taken, including the pathology result report),
3. Observation file, traffic accident report, judicial report, judicial record, alcohol report, insured's statement when necessary,
4. Epicrisis (discharge) report,
5. Laparoscopic /arthroscopic / endoscopic surgery videos when necessary.
6. Information and documents for identity determination in accordance with the Regulation Regarding the Prevention of Laundering of Crime Revenues and Measures to Prevent Terrorism Financing (www.masak.gov.tr) published by Financial Crimes Investigation Agency (MASAK)

In order for the payments within coverage to be made while documenting the outpatient treatment costs, documents below should be submitted to the insurer attached to the Health Insurance Patient Information Form.

For physician examinations;

1. Invoice showing the physician's fee (doctor stamp and branch should be stated) or self-employment invoice (sales slips are invalid)
2. If ultrasound is performed during examination, original print or the report (medical records when necessary)

For Medicine Costs;

1. Original prescription of the related physician (and the physician's report when necessary),
2. Sales slip or invoice,
3. Medicine labels and barcodes containing the drug's name and price,
4. Physician's report for the constantly used medicines

For Analysis/X-ray and Advanced Diagnosis Methods,

1. Physician's request letter / transfer note or report,
2. Invoices showing the related expenses,
3. Examination results, reports, medical records when necessary.

For Physical Treatments;
1. Imaging results requiring the treatment (MR, ultrasound, etc.),
2. Physician's request letter, detailed report showing the treatment planned (necessary treatment for each session and total sessions should be stated).

For Supplementary Medical Material;
1. Physician's prescription
2. Physician's report and analysis results when necessary

ARTICLE 8 EMERGENCY SITUATIONS

The conditions and diseases listed below are defined as emergency. The treatment costs required for the insured to recover from the death (to become stable) under the Emergency Situation shall be covered within the limit stated in the policy. In such cases, the costs to be incurred in non-contracted health care providers will be assessed in accordance with special and general conditions of the policy, based on the participation rate determined for the contracted organizations.

• Drowning in the water,
• Traffic accident,
• Sharp object injuries,(it is valid where the insured is not the preparer of the event, s/he is accidentally exposed to it)
• Rape
• Falling down from height (In the event of a life-threatening situation)
• Severe occupational accidents, loss of limb
• Electric shock,
• Freezing, cold stroke
• Heat stroke,
• Severe burns, (2nd degree and above)
• Severe eye injuries
• Poisoning
• Anaphylactic shock
• Spinal and lower extremity fractures
• Heart attacks and rhythm disorders, hypertension crises,
• Severe acute respiratory problems,
• Situations that cause loss of consciousness
• Sudden paralysis,
• igh fever (over 39,5)
• Diabetic and uremic coma
• Dyslipidemia accompanied by general impairment
• Acute abdomen,
• Acute massive bleeding,
• Meningitis, encephalitis, brain abscess,
• Renal colic,

ARTICLE 9 ACCEPTANCE TO INSURANCE AND NEW BUSINESS/RENEWAL APPLICATION

This insurance covers the persons between 18 and 65 year-old. Insurance entry age is accounted by taking into account the commencement date of the policy and the year of birth. With this contract, the health policies can be issued and taken within insurance coverage only for foreign nationals (non-Turkish citizen). It is compulsory that the insured or the insured candidate resides within the borders of Turkey.

In the acceptance to insurance coverage, UNICO SİGORTA A.Ş reserves the rights to or not to carry out comprehensive risk assessment, to or not to accept the person to the insurance and to issue the policy as a new business or renewal. The Insurer reserves the right to reject the first applications or the applications for the subsequent years without giving any reason or to accept it under the special

conditions by adding additional premium and/or waiting period for certain diseases and/or exception, limit, participation rate, and in the event a comprehensive risk assessment is made, to subject to medical examination and to request additional examination if necessary.

Comprehensive risk assessment: It is made by receiving a detailed health declaration and a set of General Health Check from the insured upon the written request of the insured who has Unisağlık - Health Insurance for Foreigners in Unico Sigorta at least for a year without interruption and in the event Unico Sigorta approves. General health check examination set is below and the expenses of these examinations shall not be covered by the policy coverage but shall be paid by the insured. Unico Sigorta may request additional examination other than this examination set. As a result of detailed risk assessment, Unico Sigortam may decide that the policy should continue as a new business. In the businesses accepted as renewal, the insurer reserves the right to accept it by applying exemptions, additional premiums, and standard conditions or under the special conditions by adding waiting period and/or special exemption, limit, participation rate due to the existing risks and/or usage.

Comprehensive risk assessment is made upon the application of the insured one month before the commencement date of the repeated policy. If the policy is interrupted / paused, detailed risk assessment shall not be made. If Unico Sigorta A.Ş. deems it appropriate, the policies which continue in Unico Sigorta longer than one year without interruption and of which detailed risk assessment has been made shall be considered as renewal and is indicated on the policy. In the policies which the insurer has accepted as renewal, waiting period shall not be applied.

GENERAL HEALTH CHECK EXAMINATION SET

MEDICAL EXAMINATION REPORT
FASTING BLOOD GLUCOSE
FULL URINE ANALYSIS
TOTAL, HDL VE LDL CHOLESTEROL
CREATININ
HEMOGRAM
EKG
SGOT, SGPT, URIC ACID
CHEST RADIOGRAPHY
PSA FOR THE MEN OVER 40-YEAR-OLD.
MAMMOGRAPHY FOR THE WOMEN OVER 40-YEAR-OLD

The policies issued without making risk assessment shall be considered as New Business and this is indicated on the policy. In the policies issued as new business, even if a person has been insured for longer than one year without interruption in Unisağlık Health Insurance for Foreigners, the 12 months of waiting period continues to be applied as the comprehensive risk assessment has not been made. Unico Sigorta reserves the right to apply an additional premium to the Insured based on the Damage / Premium rate during the policy renewal period. In the renewal period, the additional premium to be applied for the policies of which D/P rate exceed 50% is limited with maximum three times. It is possible for the insured person to continue his/her policy up to the age of 65 (including aged 65 years), provided that the insurer deems appropriate.

Whether it is declared or not, any health costs incurred for any complaints / inconveniences / diseases which exist before the commencement date of this policy and relapse and

complications of these diseases (whether it is diagnosed and/or treated) are out of coverage of this insurance and shall not be paid.

In this product, the transition from another company is not accepted. The acquired rights of the insured which the insured has previously owned with a different health insurance policy in a different company shall not be valid for this policy. The rights which exist in the special conditions and/or coverage of the previous policy of the insured but not valid in the policy special conditions of Unico Sigorta, not exist in special conditions/coverage shall not be considered as acquired rights. Only the special conditions/coverage existing in Unico Sigorta Policy shall be valid for the insured.

ARTICLE 10 RENEWAL GUARANTEE

In this policy issued for foreigners, there isn't any renewal guarantee.

ARTICLE 11 CRITERIA TO DETERMINE THE PREMIUM

The insurer determine the prices of Private Health Insurance on an individual basis by considering the criteria such as age, gender, insurance period, usage rate at previous period (health costs / premium rate), coverage structure, coverage limit and the province where medical expenses will be used, commission rate, whether the policy is issued as a new business or renewal, inflation rate. The premiums may be recalculated and changed by the insurance company in accordance with the above criteria when deemed necessary.

The insurance premium may be paid in advance or in installments. The terms and amounts to be paid are indicated on the policy and the insured pays premiums in accordance with this payment plan.

The policy premium is calculated on the basis of the age at the commencement date of the insurance (calculation of commencement date and birth date difference as year-year).

ARTICLE 12 TERMINATION AS A RESULT OF FAILURE TO PAY THE PREMIUM/INSURED'S REQUEST

If the insured fails to pay the advance payment till end of the day when the policy is delivered after the insurance payment is decided to be paid in advance or in instalments; the insurance becomes overdue. Similarly, in case any of the premium instalment within the payment plan as mentioned in the policy with exact due dates isn't paid till the end of the due date by the insurant, the policy becomes overdue. If the premium payment is overdue, the provisions of Turkish Commercial Code are applied.

In order for the policy to be cancelled by the company upon the request of the insurant and/or insured for any reason, submission of a new private health insurance agreement covering the residential permit period in accordance with the Circular, cancellation of the residential permit, a document demonstrating that the policy is covered by the General Health Insurance in accordance with Social Insurance and Law of General Health Insurance numbered 5510 are mandatory.

Without these documents or in case the policy is cancelled due to the premium debts, the right of the insurer to provide information to the Ministry of Internal Affairs, General Directorate of Immigration Processes is reserved.

In case the insured/insurant asks for cancellation within the first 30 (thirty) days after the policy issue date, paid premiums are refunded to the insurant without any deductions if the risk hasn't occurred. If the risk occurs within the first 30 (thirty) days and in all cancellation requests exceeding this date, premiums equal to the period when the insurer's liability continued is calculated based on number of days and the excess amount is refunded to the insurant.

The amount to be refunded to the insurant due to cancellation is calculated by considering the amount deserved by the insurer and the paid compensation, like below.

• If compensations paid to the insured do not exceed the insurer's earned premiums, earned premium amount is deducted from the premiums paid by the insurant and refunded to the insurant.

• If compensations paid to the insured exceed the insurer's earned premiums, but do not exceed the premiums paid by the insurant, compensation amount is deducted from the premiums and refunded to the insurant.

• If compensations paid to the insured exceed the premium amount earned by the insurer and the premiums paid by the insurant, premium isn't refunded.

When the risk occurs, the part of the undue premium instalments, which does not exceed the compensation amount that the insurer is obliged to pay, becomes overdue.

For requests of person deductions (spouse, child, etc.) after the policy commence date, processes are carried out according to the rules defined above.

If the Insurant dies, the policy becomes invalid. If the Insurant and the insured(s) in the policy are different and the insured(s) want to change the insurant and continue with the policy, written approval of the Insurant's legal successors should be submitted to the Insurer.

In such a case, the insurant is changed and the policy continues. In cases when the legal successors' approval isn't obtained, processes are carried out within the cancellation criteria stated above and premium refund is made to the legal successors if any. In a single person Policy where the Insurant is the same person as the insured, the policy becomes invalid when the Insurant dies. Upon the written request of the insurant's legal successors, processes are carried out within the cancellation criteria stated above and premium refund is made to the legal successors if any.

In policies where there are more than one insured, if one of the insured people dies, the dead insured is excluded from the policy as of the date of death. Premium refund, if any, is made to the Insurant in the policy within the cancellation criteria stated above.

ARTICLE 13 SAGMER (INSURANCE INFORMATION AND SUPERVISION CENTER) INFORMATION

Policy and health information of the insured people on this policy will be transferred to Sagmer (Insurance Information and Supervision Center), and the policy and health information of the insured can be obtained from Sagmer and other public institutions. Sending the requested information is mandatory in accordance with the Insurance Information Center Regulation, and the Insurer has no liability due to such information submitted to the Information Center.

ARTICLE 14 INFORMATION ON PROTECTION OF PERSONAL INFORMATION

Disclosure Obligation

Pursuant to the Personal Data Protection Act ("KVKK") No. 6698; acting as the Data Supervisor, Unico Sigorta A.Ş. shall record, store, update for continuing insurance services, in cases permitted by legislation Unico Sigorta A.Ş. (refers to Kibele BV and investors and/or subsidiaries, affiliates, joint ventures and all branches and offices thereof) shall be able to disclose to third parties, transfer, classify and deliver in the details specified below and be processed as specified in the KVKK, in the context explained below.

Purposes and legal reasons for processing personal data

Use in non-life insurance and non-life insurance products and services we can offer you under the Insurance Law and other legislation; record identification, address and other necessary information to identify the person performing/procuring performance of the transaction; arrange all records and documents that shall constitute basis for the transaction in electronic (internet/mobile etc.) or paper medium; comply with storage, reporting, informing obligations set forth in the legislation, by the Republic of Turkey Prime Ministry Undersecretariat of Treasury and other authorities; perform the requested insurance activities, provide other products/services and fulfill the requirements of the agreement.

Persons/institutions personal data can be transferred to for the aforementioned purposes

Persons or institutions permitted by provisions of the Insurance Law and other legislation; including but not limited to financial institutions and other third parties specified in article 31/A of the Insurance Law No. 5864; domestic or foreign reassurers due to reassurance transactions under insurance activities; regulatory public and/or private legal entities such as the Republic of Turkey Prime Ministry Undersecretariat of Treasury, CMB, BRSA, RTCB, FCIB, SBM, the Republic of Turkey Ministry of Finance; our direct/indirect domestic/foreign affiliates; institutions and domestic/foreign banks, insurance and reassurance company from whom our Company purchases services, makes cooperation or establisher partnerships to perform and fulfill obligations related to activities subject to the purposes specified in the legislation; and other persons and institutions deemed suitable by Unico Sigorta A.Ş..

Collection method of personal information

Your personal data can be collected in verbal, written or electronic medium through all kinds of digital channels such as the Head Office, Branches, Agencies, contracted brokers, third party partners, our mobile application, all channels through which Agencies provide service (ATM, kiosk, web branch, call center etc.), Company Website and the call center at 08502222800.

Your rights pursuant to article 11 of the Personal Data Protection Law

By applying to our Company you are entitled to a) learn if your data has been processed; b) if processed, to request information; c) learn the purpose of processing and if used for the intended purpose; ç) learn transferred domestic / foreign third parties; d) request correction if processed incompletely/incorrectly; e) request erase / destruction in the context of the terms specified in article 7 of KVKK; f) request notification of the transactions performed pursuant to the aforementioned items (d) and

(e) in transferred third parties; g) object to any result against you due to analysis exclusively by automatic systems; ğ) claim compensation of loss in case you suffer loss due to illegal processing. Your rights in this scape have entered into force as of 07/10/2016.
This Information and consent letter in an attachment to and an integral part of the Insurance Policy signed with Unico Sigorta A.Ş..

In the context of the aforementioned explanations and in compliance with the Personal Data Protection Law No. 6698 I grant consent to Unico Sigorta A.Ş. to collect, process, update, periodically check my personal data and hold or store on database and when necessary share with relevant public institutions and organizations and service providers in Turkey or abroad and Unico Sigorta A.Ş. (refers to Kibele BV and investors and/or subsidiaries, affiliates, joint ventures and all branches and offices thereof) and for my personal data to be kept and stored thereby.

ARTICLE 15 LIABILITIES OF THE INSURANT

In addition to the obligations of the Insurant as stated in the Health Insurance General Conditions, in case the people to be included in the agreement based on the definition of people to be insured become inappropriate to this definition anymore, this has to be notified to the insurer at most within 30 days on such a date, and the insurer has to request the exit of such people from the agreement scope.

In case the policy is cancelled and the insured is excluded from the policy scope, the liability of returning the documents prepared on the name of these people, who are then excluded from the policy scope, to the insurer belongs to the insurant. Any losses resulting from the failure to deliver the documents completely are recoursed to the insurant.

In case the statement of the insurant/insured is incorrect, deficient or wrong, provisions of Article 6 of Health Insurance General Conditions are applied. According to Article 6, provided that the rights of insurer are reserved, the insurer has the right to evaluate or conditionally accept (out-of-coverage, additional premium, etc.) the diseases of the insured/insurant under the coverage. Insurer has the right to charge the expenses contrary to the Health Insurance General and Special Conditions of the policy and payments done outside the coverage from the insured and/or insurant.

In case the insurant is different from the insured, it is deemed that the insurant has learned all health status information of the insured and signed the agreement.

ARTICLE 16 CHANGES TO BE MADE IN THE AGREEMENT

In case the coverage is extended as a result of a change offered by the Insurant and accepted by the insurer, new coverage is valid for the disorders that occur after the date of such coverage and which are included in that coverage, and standard waiting periods are restarted.

ARTICLE 17 INFORMING OFFICIAL INSTITUTIONS

Insurance Company is obliged to submit the policy and health information of the insured's on this insurance policy to the Insurance Information Center, Undersecreteriat of Treasury and SAGMER as required by legal regulations. Each person buying a health insurance is deemed to have accepted that all kinds of information obtained by the company during the issuance of this insurance agreement (loss,

coverage details, health information, personal information, etc.) will be submitted to official institutions if requested.

ARTICLE 18 CHANGES IN LAWS

This Insurance Agreement is subject to the related regulation of the Republic of Turkey.

ARTICLE 19 TAXES

All official stamp duties and fees and taxes belong to the insurant.

ARTICLE 20 CURRENCY

In all payments are done to the insurer or the insurant are in Turkish Lira.