FİT - HEALTH INSURANCE FOR FOREIGNERS IN TURKEY

SPECIAL CONDITIONS OF HEALTH INSURANCE FOR FOREIGNERS

1 - SUBJECT AND COVERAGE OF THE INSURANCE:

Groupama Sigorta insures outpatient and inpatient diagnosis/treatment expenses incurred by the insured(s) whose name(s) and date(s) of birth are specified on the policy and the schedule as a result of a disease or an accident occurred in the course of their private and work life during the validity of the insurance contract in accordance with the General Conditions for Health Insurance and these Special Conditions as subject to the coverages, limits and contributions specified on the attached policy.

This policy is valid between the inception date and the expiry date specified on the policy.

2 - DEFINITIONS:

2.1 - PERSONAL INSURANCE means insuring of a person alone or in conjunction with dependents of him/her.

2.2 - INSURANCE POLICY means a document executed between the Insured and the Insurance Company, setting out the reciprocal rights and obligations of the parties and evidencing the insurance contract.

2.3 - POLICY HOLDER means in respect of personal insurance lines a person who executes the insurance contract, acts on behalf of the insured(s) and undertakes the premium payment obligations.

2.4 - INSURED PERSON means a person who has completed the application form / health declaration pursuant to the general and special conditions of the policy and to whom insurance has been provided, and dependents of that person who are included in the insurance.

2.5 - DEPENDENT PERSONS mean spouse and/or unmarried children under 25 (including), unmarried step children under 25 (including) and unmarried adopted children under 25 (including) of the insured person.

2.6 - PLAN means one of health insurance products designed as a package containing a combination of various benefits, limits and deductibles and offered as a Private Health Insurance.

2.7 - LIMIT OF COVERAGE means the limit of coverage specified on the policy for benefits without Insured's contribution, which is equal to the maximum sum insured payable. For the benefits with Insured's contribution, the maximum amount of indemnity payable is the amount remaining after deduction of the Insured's contribution from the limit of coverage.

2.8 - CONTRIBUTION means Insured's contribution to each expense included in the coverage at the rate specified on the coverage plan.

2.9 - WAITING PERIOD means the period which must elapse since the inception date of the insurance in order for the Insured to use the respective benefit.

2.10 - EXISTING DISORDER means a disorder the sign, symptom, diagnosis or treatment of which dates back to before the inception date of the insurance as well as any disorder developed as a result of such disorder.

2.11 - CONGENITAL (INNATE / NATAL) AND STRUCTURAL DISEASES AND DISABILITIES mean such diseases and disabilities existing at birth and/or developed as a result of a structural disorder and occurred at the time of birth or at any time of the life.

2.12 - HEREDITARY DISEASES mean such diseases and disabilities inherited genetically.

2.13 - DIAGNOSIS means determination of the disease of the insured or the condition developed as a result an accident incurred by the insured by means of signs and findings (results of physical examination, tests, X-ray, tomography, endoscopy, etc.).

2.14 - TREATMENT means any medical and surgical procedure implemented to cure a disease of the Insured or an injury incurred by the Insured as a result of an accident.

2.15 - HEALTHCARE INSTITUTION means an institution licensed to carry out outpatient (polyclinics of hospital, diagnosis and treatment centers, doctor's consultation rooms) and/or inpatient (hospitals) medical and surgical procedures in the country where it is situated.

2.16 - CONTRACTED HEALTHCARE INSTITUTIONS (LIST OF HEALTHCARE INSTITUTIONS CONTRACTED FOR HEALTH INSURANCE PROVIDED TO FOREIGNERS) mean authorized healthcare institutions of which names are notified to the Insured for health insurance provided by the Insurer to foreigners.

2.17 - SCOPE OF COVERAGE means all of healthcare expenses which the Insurer has undertaken to pay under the coverages specified on the policy.

2.18 - NON-CONTRACTED HEALTHCARE INSTITUTIONS mean healthcare institutions outside the institutions defined in paragraph 16 of article 2.

2.19 - TARIFF means the tariff published by the Turkish Medical Association (TTB), specifying the fees of doctors who perform their profession within the boundaries of the Republic of Turkey and the principles of implementation. The tariff fee is calculated by multiplying the "unit value" specified for each medical procedure by the coefficient established for each province in the book titled "TTB's Minimum Fee Tariff".

2.20 - EARNED RIGHTSmeans such rights granted by insurance companies to persons who have a health ınsurance policy. Earned rights are evaluated by making a medical risk assessment according to the health condition of the Insured as specified in the personal reports received from other insurers or healthcare institutions.

2.21 - TERM OF INSURANCE means the period starting at 12:00 hours noon and ending at 12:00 hours noon by Turkish time on the days specified as inception and expiry dates on the policy, unless otherwise agreed. Liability of the Insurer commences on condition that the whole amount or, if the parties have agreed on payment of the premium in installments, the down payment of the premium has been paid. The inception date of the insurance shall be the date when the application form is received by the Insurer for new insurance policies and the expiry date of the policy for renewed and transferred policies.

3 - COVERAGES:

This insurance provides those of the following benefits which are specified on the policy based on the limits and practices specified on the policy in accordance with the General Conditions for Health Insurance and

these Special Conditions. You can find a list of the Contracted Healthcare Institutions where this policy is valid on the web site of the company at www.groupama.com.tr (health insurance for foreigners).

3.1 - INPATIENT TREATMENT EXPENSES COVERAGE:

This coverage insures the Insured against expenses of treatment which required hospitalization of the Insured for minimum 24 hours, expenses of surgical treatment at a cost of 150 units and above, expenses of ectopic pregnancy, liver biopsy, chemotherapy, radiotherapy and dialysis procedures, cardiac and cerebral angiography and, in the event of death of the Insured after hospitalization, morgue expenses in accordance with the limit of coverage and contribution. At non-contracted healthcare institutions, a limit of TL 20,000 and a contribution of 20% by the Insured shall be applied.

Chemotherapy, radiotherapy, dialysis drugs, drugs used in the course of inpatient treatment are limited with TL 10,000 in aggregate annually.

Any expenses incurred in the course of inpatient treatment which are irrelevant with the diagnosis shall not be paid; any expenses included in the coverage which were incurred for inpatient treatment of a condition despite the fact that the inpatient treatment was not necessary for that conditions shall be paid out of the outpatient treatment coverage. For the Room and Intensive Care Unit coverages and the all inpatient treatment coverages in total, expenses shall be paid within the limits of coverage up to 180 days. The intensive care unit coverage is limited with 90 days at most.

Inpatient treatments continuing as of the expiry date of the insurance are valid until the end of the inpatient treatment, providing that this period does not exceed 10 days, on condition that the policy is not renewed by Groupama Sigorta or any other insurance company.

Physician's fee at a contracted healthcare institution shall be paid in such a way that it shall not exceed the contracted prices established by the respective institution for Groupama Sigorta or, if there isn't any physician fee established by the institution for the performed procedure, the current price system of the institution and/or the contracted price system established for Groupama Sigorta. If, at the contracted healthcare institution, the physician is not a staff member of the institution, maximum the respective fee specified in the minimum fee tariff of the TMA shall be paid.

Calculation of the surgery fee payable:

In respect of surgeries performed with the same incision during the same session;

* 100% of the unit specified in the Tariff for the 1st surgery
* 50% of the unit specified in the Tariff for the 2nd surgery
* 25% of the unit specified in the Tariff for the 3rd surgery
* 12.5% of the unit specified in the Tariff for the 4th and subsequent surgeries

shall be taken as basis to make the calculation.

In respect of surgeries performed with a different incision during the same session;

* 100% of the unit specified in the Tariff for the 1st surgery
* 100% of the unit specified in the Tariff for the 2nd surgery
* 50% of the unit specified in the Tariff for the 3rd surgery
* 25% of the unit specified in the Tariff for the 4th and subsequent surgeries

shall be taken as the basis to make the calculation.

3.2 HOSPITAL ROOM EXPENSES COVERAGE

This coverage insures the Insured against standard room and meal expenses incurred for inpatient treatment of the Insured at a hospital in accordance with the daily limit of the coverage and the contribution as specified on the policy. For the Room and Intensive Care Unit coverages and all inpatient treatment coverages in total, the expenses shall be paid within the limits of coverage and up to 180 days at most. Expenses of the accompanying person are not included in the coverage.

3.3 - INTENSIVE CARE UNIT EXPENSES COVERAGE:

This coverage insures against intensive care unit expenses (bed and boarding charges, charges for use of equipment used for intensive care, charges for monitoring and other similar machines, supplies necessarily used for procedures carried out in the course of intensive care, charges for pneumatic bed and IV pump) incurred if the Insured received inpatient treatment at a hospital in accordance with the daily limit of the coverage and the contribution.

Expenses incurred for tests and treatments carried out in the course of intensive care (physician's tracking fees, laboratory and drug expenses, any charges not specific to intensive care) are considered within the scope of the inpatient treatment coverage.
Expenses of the accompanying person incurred in the course of stay in the intensive care unit are excluded from the coverage.

The intensive care unit coverage is limited with 90 days at most.

3.4 - OUTPATIENT DIAGNOSIS / TREATMENT EXPENSES COVERAGE

This coverage insures against expenses incurred for physician's examination, diagnostic laboratory tests, all endoscopic procedures, endoscopic minor surgical interventions (such as polypectomy), endoscopic biopsy, fine-needle aspiration biopsies, angiographies (excluding cardiac and cerebral angiographies), MR, MR angiography, radiographic examinations, nuclear medicine and algology procedures, etc. carried out outpatient at a doctor's consultation room or a healthcare institution up to a limit of TL 2,000 in aggregate annually and up to 60% of the cost at contracted and non-contracted healthcare institutions.

In the event that the attending physician is not a staff member at a contracted healthcare institution, the diagnosis, treatment, physical therapy charge shall be paid up to the fee specified in the minimum fee tariff of the TMA. Costs of diagnostic methods (ultrasound, smear test, etc.) performed by the physicians in the course of their examination as an assistance to their diagnosis shall be considered within the physician's examination fee.

For Minor Intervention, expenses incurred for dressing, injection, ear wash, plaster cast, oxygen supply, abscess drainage, gastric lavage, transfusion, mole and wart removal (nevus, verruca), lipoma removal, parasynthesis, cauterization, cryotherapy, and monitoring equipmentused at hospital, expenses incurred for consultation bed and similar interventions, expenses incurred for surgical interventions up to a cost of 149 units as specified in the tariff, consumables used in the course of intervention for outpatient treatment of the Insured are included in the outpatient treatment coverage and expenses for examinations, tests and drugs are paid out of the outpatient treatment coverage. Physician fees for surgical interventions shall be calculated as specified in article 3.1.

For Drug Expenses, payments made for drugs prescribed by a physician for outpatient treatment shall be paid in accordance with the annual limit, contribution and deductible specified on the policy out of the outpatient treatment coverage.

Maximum drug dosage that can be purchased in one go may not be longer than two months on condition that it does not exceed the expiry date of the policy. The period between the date of prescription and the date of purchase of the drugs must not be longer than 7 days. If there are continuously used drugs, the insured persons whose policy is in effect can purchase the drugs by photocopy of the prescription for 1 year from the date of the prescription.

Physician examination fees at a non-contracted healthcare institution are limited with the minimum fee tariff of the TMA, and the physician's diagnosis, treatment, surgery and follow-up fee shall be paid without exceeding the tariff.

3.5 - AUXILIARY MEDICAL SUPPLY COVERAGE:

This coverage insures against costs of portable, special-to-person supplies used as an external support to body and for medical purposes only as part of a treatment provided as a result of an accident or a disease occurred during the term of the insurance in accordance with the limit of coverage and contribution specified on the policy.

3.6 - DOMESTIC EMERGENCY ASSISTANCE SERVICE:

Domestic emergency assistance services are carried out by an assistance company designated by Groupama Sigorta.

GEOGRAPHIC LIMIT

Services are valid within the boundaries of Turkey.

DOMESTIC EMERGENCY ASSISTANCE SERVICE

A) MEDICAL SERVICES

1. Medical Information and Consultancy

Regarding any health problem, whether it be emergency or not, information is provided to the Insured about the health problem incurred by him/her. Names, addresses and telephone numbers of doctors, specialist doctors, dentists, hospitals, diagnostic centers, and pharmacies are informed. Recommendation is given about the measure required to be taken about the health problem, but diagnosis is not put and drug is not recommended.

2. Medical Transportation

Transportation to Hospital

In an emergency such as bodily injury or a serious disease threatening the life of the Insured, Assistance Company shall arrange transportation of the Insured to the nearest hospital or healthcare institution having the necessary equipment by land or air ambulance.

Transportation from one Hospital to Other

When necessary, direct transportation of the Insured under the necessary observation by a vehicle (land/air ambulance, scheduled flight) arranged by the assistance company to a hospital having more appropriate equipment special to the bodily injury or the disease shall be arranged. Transportation from one medical center to another shall be provided only if the equipment and medical team required for the

treatment to be provided to the patient lack in the medical center where the Insured is staying. In order to provide the transportation, a medical report issued by the attending physician is required.

Transportation to Home / Hospital nearby Home

Upon completion of the treatment, direct transportation of the Insured under the necessary observation by a vehicle arranged by the assistance company to the city of permanent residence or an appropriate hospital or a medical center nearby the home of the Insured shall be provided. The medical team of the assistance company and the attending physician shall decide whether the health condition of the Beneficiary is convenient for transportation of his/her as an ordinary passenger or other additional arrangements are necessary, and determine the means of transportation (land ambulance, air ambulance, scheduled flight, etc.) appropriate for the bodily injury or the disease in accordance with the written report of the attending physician.

3. Delivery of Required Drugs

In the course of a travel, prescribed drugs of which equivalents are not available (of which medical requirement has been approved by the medical team of the assistance company) shall be provided, the costs of which shall be paid by the Beneficiary. Transportation cost shall be paid up to 10 kg.

4. Accommodation at a Hotel upon Discharge from a Hospital

Following stay of the Insured at a hospital outside the province where the Insured resides within the boundaries of Turkey, if the attending physician and the medical team of the assistance company deem necessary, accommodation of the Insured at a convenient hotel for 5 consecutive nights shall be paid up to USD 100 per night.

5. Transportation of Accompanying Person

If the Insured stays at a hospital for longer than 7 days, transportation cost of a relative designated by the Insured to accompany the Insured shall be paid. Domestic return bus ticket or, for a distance exceeding 500 km, return economy class airplane ticket shall be provided.

6. Accommodation Expenses of Accompanying Person

If the Insured must stay at a hospital for longer than 7 days, expenses of accommodation consisting of room and breakfast of a close relative of the Insured at a maximum 4* hotel or at the hospital where the Insured stays for 7 consecutive nights shall be paid. If there isn't a 4* hotel or a vacant room at 4* hotels in the area where the hospital is situated, the accompanying person shall be provided with a room in a 3* hotel. Hotel shall be chosen by the assistance company.

7. Return of Unattended Children

Return of the children at and under 15 years old accompanying the Insured in the course of travel during the medical care of the Insured to their residence in accompany of an accompanying person shall be paid (by using their tickets if any). Domestic return bus tickets or, for a distance exceeding 500 km, return economy class airplane tickets shall be provided.

8. Arrangement of Return to Residence after Treatment

Upon completion of the treatment outside the city of permanent residence, transportation of the Insured to the permanent residence shall be arranged and the related expenses shall be paid. Medical team of the

assistance company and the attending physician shall decide whether the health condition of the Beneficiary allows transportation of him/her as an ordinary passenger or any additional arrangements are necessary, and determine the means of transportation (land ambulance, air ambulance, scheduled flight, etc.) appropriated for the bodily injury or the disease in accordance with the written report of the attending physician.

9. Transportation of Body of the Insured in accordance with Medical Conditions

In the event of death of the Insured outside the city of permanent residence, the assistance company shall take all measures for arrangement of transportation of the body to the place of burial within the boundaries of Turkey. Expenses of funeral and burial are excluded from the coverage.

10. In the Event of Death of the Insured, Return of Family Members

In the event of death of the Insured outside the city of permanent residence, if return of the family of the Insured by pre-arranged means to home is not possible, the assistance company shall arrange return of the heirs to the permanent residence by using the existing tickets and pay the expenses.

11. Unplanned Return to Permanent Residence (in the event of death of a relative)

If the Insured must urgently return to the permanent residence due to death of a relative at the residence, the assistance company shall arrange return of the Insured and pay the transportation expenses.

Domestic return bus ticket or, for a distance longer than 500 km, return economy class airplane ticket shall be provided.

* Upon return, the Beneficiary must certify the death by an official document.

12. Monitoring of Health Condition of a Relative of the Insured

In the event of bodily injury or disease of a relative of the Insured, the health condition of the relative is followed up and changes in his/her condition are reported by the medial team of the assistance company to the Insured.

13. Sending of Urgent Messages

In the cases intervened by the assistance company, the assistance company arranges exchange of urgent messages between the Insured and his/her friends, business circle and relatives at the place of residence if requested.

GENERAL EXCLUSIONS TO THE DOMESTIC EMERGENCY ASSISTANCE SERVICE

The Insured shall not have the right to recover any expenses directly paid by him/her without prior consent of the assistance company, except for Land Ambulance. Charges for Land Ambulance shall be paid within the limits of the respective benefit.

2- Claims arising from the following causes are excluded from the coverage:

a) War, invasion, acts of foreign enemy, hostilities (whether war be declared or not), civil war, insurrection, mutiny, terrorist-military-police forces, civil commotion.
b) Self-inflicted injury or complicit of the Insured in a crime.

c) Any loss, damage or injury incurred in the course of participation of the Beneficiary as a competitor in a car race or show.
d) Any loss, damage or injury resulting from involvement of the Beneficiary in a fight, except for self-defense.
e) Any loss, damage or injury resulting from engagement in any sports as a professional or trainer for an official competition or show.
f) Any loss, damage or injury caused or contributed directly or indirectly by ionizing radiations from any nuclear fuel or from radioactive contamination or radioactive, poisoning or other dangerous characteristics of any explosive nuclear compound or nuclear component.
g) Any loss resulting from total or partial work disability occurred while being under the effect or because of the effect of alcohol poisoning or poisoning from a drug (except for a drug taken for treatment by instruction and prescription of a licensed physician).
h) Death, injury or disease as a result of suicide or attempt thereat.
i) Any incident associated with pregnancy or voluntary abortion until 3 months before the expected date of delivery.
j) Any incident in which the Insured inflicted harm to himself/herself, any third persons and environment due to a mental disease or loss of personality.

OBLIGATIONS OF THE INSURED

In an emergency, the Insured must call the head office of Groupama Sigorta in İstanbul at phone number 0 850 250 50 50 by dialing "0" around the clock before making any personal attempt and inform

* His/her name and last name and dates of inception and expiry of the policy;
* His/her address and telephone number by which he/she can be reached;
*The problem encountered by him/her and the type of assistance requested by him/her.

MEDICAL TRANSPORTATION

If the Beneficiary applies for medical transportation, he/she must provide the following:

i) In order to enable the assistance company to intervene immediately,

* name, address and telephone number of the hospital to which he/she or a dependent of him/her has been taken;
* address and telephone number of the attending physician and the family doctor, if any.

ii) Medical team or representatives of the assistance company shall have free access to the room of the Beneficiary in order to be able to determine the condition of the Beneficiary. If this obligation is not fulfilled except for a justifiable objection, the Beneficiary shall not be entitled to any medical assistance.

iii) In any case, the assistance company shall determine the date and vehicle of transportation in agreement with the attending physician.

iv) In the event of a bodily injury which requires hospitalization, the Beneficiary or the person acting on behalf of the Beneficiary shall notify the assistance company within 48 hours following the date of occurrence of the incident. If this notification is not given, the assistance company shall be entitled not to pay the incurred expenses to the Beneficiary.

GENERAL PROVISIONS

i) Limitation
Upon occurrence of a loss or damage which may give rise to a claim, the Beneficiary is obliged to exert effort to limit or stop the loss or damage. All expenses incurred outside the coverage and amounts paid on behalf of the Beneficiary shall be recovered from the Beneficiary on condition that prior consent of him/her has been obtained. If the Insured does not give such consent, the assistance company shall be obliged to pay the incurred loss within the assistance limits upon the demand of the insured.

ii) Recovery
The Beneficiary shall furnish all required documents to the assistance company and carry out such formalities in order to enable the assistance company to receive payments from the concerned sources.

DELIVERY OF BOND

If security money is to be paid on behalf of the Insured, the Insured is obliged to sign a note payable in consideration of the amount to be paid. The note payable can also be signed by a relative of the beneficiary.

OTHER MATTERS

You can find all conditions of the policy at **www.groupama.com.tr.**

4 - WAITING PERIODS

4.1 - Expenses incurred for outpatient diagnosis, outpatient treatment, minor procedure, surgical and inpatient diagnosis and treatment of the following diseases and complications are excluded from the coverage for 12 months following the date of being insured by Groupama Sigorta first time ever, except for the cost of the physician's initial examination:

Cardiac, Cancer, Organ Transplantation and Organ Failure, Adhesiolysis, Chronic Diseases (Diabetes, Hypertension, COPD, MS, etc.), Hernias, Hemorrhoid / Anal Fistula, Anal Fissure / Anal Abscess, Perianal Abscess, Bartholin's Abscess/Cyst, Breast Diseases, Tonsillitis, Adenoid, Thyroid Gland Diseases/Goiter, Otitis Media, Cataract, Glaucoma and Retinal Diseases, Disc Diseases (Discopathy), Gall Bladder and Biliary Track Diseases, Urinary System Stone, Ovary Cyst, Myoma and Prostate Diseases, Sinus Pilonidalisis, any benign tumor - Mass - Polyp - Lipoma - Nevus Wart (Verruca), Cyst, Carpal Tunnel Syndrome, Ulnar Tunnel Syndrome, Varicose, Coxarthrosis, gastroesophagial reflux, peptic ulcer, auto-sclerosis, endometriosis, endometrioma, sinusitis, hygroma, stress incontinence, cystorectocele, shoulder and knee surgery (meniscus, cartilage, synovia and ligament lesions, etc.).

Provided that the Insurer may both extend the waiting periods applicable to the above stated diseases and impose waiting period for any diseases apart from them after evaluating the declaration/documents of the insured/policy holder on condition that they are specified on an endorsement to the policy.

4.2 - Every kind of physical therapy and rehabilitation expenses and algology procedures are excluded from the coverage for 12 months following the date of being insured first time ever by Groupama Sigorta or by another insurance company, providing that earned rights are granted.

If those insured persons who have purchased only inpatient treatment policy from the date of being insured first time ever shift to a plan providing outpatient treatment, they shall be subject to a waiting period of 12 months for outpatient physical therapy and algology procedures.

5 - EXCLUSIONS:

In addition to Article 2 of the General Conditions for Health Insurance, any disease and/or accident incurred by the insured persons during the term of the insurance due to any of the following events and any conditions developed from such events shall be excluded from the coverage:

5.1 - Expenses incurred for investigationand treatment of any disorder and disability of the insured person existing before the inception date of the insurance or of any congenital and/or structural disease and disability, for diagnosis and treatment of any hereditary disease and disability and any disorder developed as a result of the same.

5.2 - Expenses incurred for physician examination and laboratory / X-ray, etc. procedures, treatments, procedures for early diagnosis of diseases, check-ups, drugs and vaccines carried out and used for purposes of investigation or protection in the absence of any disease of the insured person.

5.3 - Any procedures carried out in the absence of any diagnostic / treatment program required by a physician and expenses incurred as a result of the same.

5.4 - All expenses incurred for any treatment which is deemed by the US FDA (Food and Drug Administration) to be in the experimental stage, any experimental treatments which have not been scientifically proven, karyopracter procedures, PRP, root cell transplantation and use of root cell outside the cancer treatments,

5.5 - All expenses related with motor and mental development disorder, growth and development disorder.

5.6 - Plastic surgeries, diagnosis and treatments for esthetic purposes, gynecomasty, transsexual surgeries, breast reduction surgery, laser epilation, laser ad phototherapy procedures related with any skin disease (except for puva therapy), telangiectasis, therapies for dermal hemangioma, superficial varicose treatments (sclerosant varicose treatment, endovenous laser treatment, every kind of laser treatment, etc.), except for cases as required by an accident incurred by the insured person after the inception date of the insurance.

5.7 - Expenses related with pesplanus and, except for cases as required by an accident incurred by the insured person after the inception date of the insurance, scoliosis, kyphosis, and lordosis.

5.8 - Expenses incurred for septum deviation, narrowness of nasal meatus and complications.

5.9 - Expenses incurred for diagnosis and treatment of concha hypertrophy and Hallux Valgus.

5.10 - Expenses incurred for coronary artery calcium scan by Electron Tomography (EBT), Volume Computer Tomography (VCT) and similar equipment, coronary artery angiographies by multi-detector computer tomography, and virtual bronchoscopy and virtual colonoscopy performed for scanning purposes.

5.11 - Expenses incurred for diagnosis and treatment of spermatocele, varicosele, hydrocele, umbilical cyst and epididymis cyst.

5.12 - Expenses incurred for diagnosis and treatment of sleep disorders, sleep apnea and snoring and for auxiliary equipment.

5.13 - Immunotherapy and allergy tests (dermal tests, determination of quantitative antigen in serum and other investigations).

5.14 - All expenses related with pregnancy and childbirth and incubation care.

5.15 - Expenses incurred for organ donation and donor.

5.16 - Breast prosthesis and nipple reconstruction after cancer surgery.

5.17 - Expenses incurred for any medical treatment, laser and surgical procedure carried out for crossed eye and reflective errors of the eye, expenses incurred for diagnosis, investigation and treatment of lazy eye.

5.18 - Expenses incurred for diagnosis and treatment of all diseases associated with AIDS, ARCS and HIV, genital herpes, genital and anal papillomatous lesions (warts, condyloma acuminatum, etc.), genital and anal contagiosum, human papilloma virus (HPV) and expenses incurred for diagnosis and treatment of venereal diseases.

5.19 - Expenses incurred for abortion, expenses incurred for sterilization (tube ligation, vasectomy, etc.), implant contraceptives, all birth control methods (spiral application, oral contraceptives, etc.), investigation of oral abortion, impotency (erectile dysfunctions), sexual dysfunction, infertility and/or fertilization (in vitro fertilization, microinjection, etc.), expenses incurred for investigations such as HSG and hysterosonography, etc., expenses incurred for investigation, control and treatments carried out to have a child without pregnancy.

5.20 - Circumcision and its complications.

5.21 Expenses incurred for physical therapy and rehabilitation received as part of an outpatient and/or inpatient treatment in excess of 20 sessions within one year of insurance.

5.22 - Expenses incurred for treatment of psychiatric, psychological disorders and treatment of psychosomatic diseases and expenses incurred for psychologists, pedagogues, social service experts, etc.

5.23 - Expenses incurred for diagnosis and treatment of geriatric diseases (dementia, Alzheimer's disease, etc.) and psycho-geriatric diseases.

5.24 -Expenses incurred for diagnosis and treatment required by a disease or an accident resulting from the insured's being under the effect of alcohol or narcotic substances, expenses incurred for diagnosis and treatment of any disease and complications developed as a result of use of alcohol or narcotic substances, expenses incurred for treatment of cigarette, alcohol and substance addiction.

5.25 - Expenses incurred for alternative medicine methods (acupuncture, hypnosis, aromatherapy, neural therapy, etc.), obesity, procedures for diagnosis of metabolic syndrome, metabolic surgery, obesity surgery, diabetes surgery, procedures for gaining weight and expenses incurred at foot care centers, expenses incurred for PRP (Platelet Rich Plasma), services used at spa cure centers, massage expenses, dietary specialists, mud baths, weight loosing centers, fitness centers and similar places, expenses incurred for anti-aging procedures, expenses incurred for diagnosis and treatment of nutrition and diet, expenses incurred at esthetic beauty centers, expenses of voice and speech therapy.

5.26 - Expenses incurred for examination, diagnosis and treatment of hair loss, expenses incurred for treatment of perspiration, iontophoresis and botox procedures, treatments with orlistat and its derivatives (xenical caps, etc.), treatments with sibutramine and its derivatives (reductil caps).

5.27 - Expenses incurred for drugs, vitamins and food supplementary products approved by the Ministry of Agriculture and Village Affairs and imported with the import license given by the Ministry of Health, which have not been registered as medicine, for medical fruit salts and medical sodas, herbal weight loss supplements, bran and plant fibers, artificial sweeteners, nicotine preparations used to quit smoking,

contact lens care preparations, every kind of tooth paste, mouth and dental care preparations, every kind of medical teas, any products prepared in drug form, containing fractions such as herb and herbal elements and herbal extract distillate, any preparations not registered by the Ministry of Health, every kind of soap, anti dandruff and anti hair loss preparations, hair or dandruff shampoo, skin cream, skin soap, cosmetic products, thermophore, thermometer, etc.

5.28 - Expenses incurred for every kind of intervention, diagnosis and treatment involving teeth, gum and jaw carried out by dentists.

5.29 - Costs of eyeglasses, contact lenses and solutions, wheeled chair, hearing aid, ICD, crutches, orthopedic boots-soles-slippers-shoes.

5.30 - Costs of diapers, baby food, feeding bottle, pacifier, baby care creams, etc.

5.31 - Expenses incurred for disability and injury occurred in the course of performance of every kind of professional and/or dangerous and extreme sports (mountain climbing, parachuting, flying other than travel by air, underwater sports, rally, motocross, use of atv-utv, etc.) and sports competitions related therewith and speed and strength races and as a result of any accident resulting from driving of a car by the insured without a valid driving license.

5.32 - Expenses incurred as a result of disability caused by participation in strikes, labor disputes involving lockouts, civil commotions, fights, etc. and for diagnosis and treatment as required by it.

5.33 - Expenses of private nursing services used at hospital in the course of outpatient or inpatient treatment.

5.34 - Costs of healthcare service received from physicians whose specialty is not consistent with the disease of the insured.

5.35 - Expenses for use of robot, etc. in robotic surgical operations.

5.36 - In the cases where the treatment must be carried out inpatient from medical point of view, indemnity for daily hospital expenses outside the scope of the limit and the contribution of the coverage specified on the policy.

5.37 - Daily work disability compensation for loss of earning of the insured due to inability of him/her to work as a result of a disease.

5.38 - If the insured becomes in need of care, expenses of care arising from reasons not falling into the scope of the Nurse Care at Home Coverage or daily care pay.

5.39 - All expenses excluded from the coverages, limits and contributions specified on the policy and any uncovered special situations specified in the additional clauses of the policy.

6 - GEOGRAPHIC LIMIT:

Policy can be issued to persons residing within the geographic boundaries of the Republic of Turkey.

7 - PRINCIPLES APPLICABLE TO IMPLEMENTATION OF COVERAGE:

Principles applicable to implementation of the coverages are explained in the section of “Coverages” of Article 3 of the special conditions.

8 - PAYMENT OF INDEMNITY:

Healthcare expenses incurred at contracted healthcare institutions

* For the healthcare expenses incurred at a contracted healthcare institution, the insured must present his/her insurance card and original passport to the representative of the contracted healthcare institution at the time of application. Applications without these documents shall not be processed by the institution for direct payment.

The insurer shall pay the expenses incurred for diagnoses and treatments included in the coverage directly to the Contracted Healthcare Institution (LIST OF INSTITUTIONS CONTRACTED FOR HEALTH INSURANCE FOR FOREIGNERS) in accordance with the insurance coverages, limits and deductibles, providing that the conditions specified in article 8.1.1 of the special conditions. The insurer has the right to make changes to, add new institutions to, or remove institutions from, the LIST OF INSTITUTIONS CONTRACTED FOR HEALTH INSURANCE FOR FOREIGNERS. You can find the list of Healthcare Institutions contracted for health insurance for foreigners at www.groupama.com.tr.

* In order that a claim for indemnity for expenses incurred at the "LIST OF HEALTHCARE INSTITUTIONS FOR HEALTH INSURANCE FOR FOREIGNERS" under the Inpatient Diagnosis / Treatment Coverage can be evaluated and, if the same are included in the coverage, paid directly to the hospital,

i- representative of the contracted institution asks authorization from Groupama Sigorta with investigation results, polyclinic record data, in the case of an accident, traffic accident report-intoxication report, in accompany of the private health insurance patient information form completed by the attending physician.
ii- Groupama Sigorta evaluates the disease of the insured which is the subject of the authorization request based on the documents sent by the healthcare institution in accordance with the special conditions of the policy, the general conditions for health insurance and the limits of coverage. If, as a result of the evaluation, the disease is excluded from the coverage of the insurance, reasons for unpaid expenses are notified verbally/in writing to the contracted institution. If the disease is included in the coverage of the insurance, the letter of "Preliminary Approval" stating that the expenses would be paid in accordance with the coverage and limits of the insured is sent to the Contracted Healthcare Institution. The preliminary approval is to the effect that the insured has a valid policy with Groupama Sigorta at the date of sending of it. The preliminary approval does not mean that the treatment expenses incurred would be absolutely paid, and it is possible that the indemnity may not be paid by Groupama Sigorta pursuant to the law and the general and special conditions of the insurance.
iii-For formalities of discharge of the insured from the hospital, the Contracted Healthcare Institution sends the surgery report, investigation results, hospital discharge report in accompany of the detailed itemized invoice for the expenses to Groupama Sigorta. Groupama Sigorta evaluates the received documents and, if the procedures performed are included in the coverage, sends a letter of release showing how much of the invoiced amount has been approved/paid to the hospital. After the insured has written his/her name and last name on the letter of release and signed it, the insured pays any expenses unpaid by Groupama Sigorta to the hospital and thus the discharge formalities have been completed.
iv-Necessary and adequate documents relevant with the disease being the subject of the indemnity claim must be provided by the hospital/physician to the insurer.
v- If the physician who carried out the procedures at the Contracted Healthcare Institution has not a contract with Groupama Sigorta, the physician shall issue an invoice separately. The insured may not benefit from direct payment in respect of this invoice.

If the aforesaid conditions have not been fulfilled, the insured may not benefit from the direct payment practice.

If it is found after the insurer has completed the direct payment procedure that the disease which caused the diagnosis / treatment is excluded from the coverage, the amount paid to the healthcare institution shall be refunded by the insured to the insurer in cash lump sum.

Asking of authorization from the Authorization Center of Groupama Sigorta at latest 48 hours beforehand, except for emergency cases, for execution of authorization transactions for inpatient treatments will prevent waiting at the Contracted Healthcare Institution.

* If it is found after the insurer has made the direct payment to the contracted institution that the disease which caused the diagnosis / treatment is excluded from the coverage, the amount paid to the healthcare institution shall be refunded by the insured to the insurer in cash lump sum.

* The insurer shall pay the amount of indemnity to a bank account notified by the insured with the claim form. In order that the indemnity can be paid, the provisional identity number (tax identity number for foreigners) must have been notified.

* Medical interventions and procedures carried out for diagnosis and treatment of a disease and/or disability of the insured must be reasonable and consistent with the general diagnostic and treatment methods special to that disease or disability.

* Indemnity shall be paid to the bank account number/IBAN notified by the insured.

* Recovery: The insurer is entitled to recover any expenses which are contrary to the Special Conditions of the Policy and the General Conditions for Health Insurance and any payments made outside the scope of the coverage from the insured together with any secondary charges.

* Subrogation: The insurer shall subrogate the insured against any responsible third persons in respect of the treatment expenses paid by it to the extent of the amount paid by it.

* Groupama Sigorta can exchange every kind of information and documents (indemnity, coverage details, etc.) about the insured with the Insurance Information Center, the Under Secretariat of Treasury and, if request received from them, every kind of state institution, in accordance with the health insurance contract pursuant to the law. Persons owning the health insurance product of Groupama Sigorta accept in advance the exchange of information and documents with public entities in accordance with the health insurance contract.

* If the insured has an examination done without request of Groupama Sigorta in order for re-evaluation of an indemnity unpaid within the term of the insurance, the expenses of examination done at the request of the insured shall not be paid by Groupama Sigorta, whether it has been decided to pay the indemnity or not.

* Claims of the insured who don't benefit from the direct payment service for outpatient or inpatient examinations and treatments at a contracted healthcare institution shall be paid in accordance with the limits of coverage based on the contracted prices established by the respective institution for Groupama Sigorta.

Healthcare expenses incurred at a non-contracted healthcare institution

After the payment of the treatment expenses of the insured to the respective institution, the following documents are sent in accompany of the claim form of which front face has been completed in full and signed by the insured and the back face by the attending physician to Groupama Sigorta. Claim form is available at www.groupama.com.tr.

1. Original invoice (on the invoice, there must be detailed breakdown of the examinations done, the medical supplies and drugs used, the surgeries done, the physician fees, etc.)
2. Original prescription, drug boxes and original of pharmacy's cash register slip
3. If an investigation was done, photocopy of its results (test, X-ray, MR, etc.)
4. If it is inpatient treatment, photocopy of the discharge report and the consultation file
5. If it is surgery, surgery report
6. When the surgical operation charge, fees of anesthetist and assistant have been invoiced separately, a breakdown the expenses incurred must be attached to the invoice of the hospital
7. If it is a condition resulted from an accident, accident report, intoxication report
8. If treatment was received in abroad, photocopy of the passport of the insured showing that the insured was in the country where the treatment was received at the date of the treatment, a document showing that the invoice has been paid
9. If it is emergency dental treatment following a traffic accident, panoramic X-ray
10. Original of the passport
11. A bank account number of the person to whom payment will be made, which is valid in Turkey

Groupama Sigorta shall process a claim after delivery of all documents required by it in addition to the above stated documents and evaluate the disorder which is the subject of the expense in accordance with the general and special conditions of the policy. If all documents have been completed, indemnity shall be paid within 5 business days.

RENEWAL OF THE CONTRACT:

This insurance is valid for 1 year at most. However, upon the request of the insured/policy holder following the expiry date of the insurance, a new policy can be issued in accordance with the terms and conditions established by the insurer.

If 30 days or more have elapsed since the date of renewal, a new application form shall be completed for the insured and the insured shall enroll in the insurance as if he/she is a new insured. Any earned rights shall not be applicable and any disease which exists and for which indemnity has been received shall be entirely excluded from the coverage, and this shall be stated in the additional clauses of the policy. A surcharge can be applied depending on the Loss/Premium ratio of the policy.
If the insured requests to shift to a different plan in the renewed term, any earned rights shall not be applicable and it shall be treated as a new business. The insurer shall decide to renew or not to renew the insurance by examining their health condition and/or their loss/premium ratio of the insured within the insurance term.
When giving its decision to renew, the insurer may request the declaration of the insured about his/her current health condition, the records of him/her pertaining to the private health insurance, and additional examinations of the insured. The insurer may obtain information from the persons and institutions who and which provided treatment to the insured. Persons who have a health insurance product of Groupama Sigorta accept in advance the exchange of information and documents with public entities in accordance with the health insurance contract.

Based on such information, the insurer may evaluate any disorder and/or disease incurred by the insured during the insurance term and may exclude the same from the coverage in the renewed term or include the same in the coverage by applying a special limit or an additional premium for the same.

For those insured persons who want to shift from the group health insurance to personal health insurance as a renewal, a risk assessment shall be made and the decision as to granting any earned rights shall be given by Groupama Sigorta A.Ş.

10 - DETERMINATION OF THE PREMIUM:

10.1 - Criteria for Determination of the Premium:

The insurance premium is calculated based on the standard tariff premiums as established for the age, the gender and the chosen plan by taking into account the criteria of loss/premium ratio of the insured, current disease risks of the insured and list of contracted institutions for health insurance for foreigners being in effect for the policy. In the establishment of the standard tariff premiums, changes in the Minimum Fee Tariff of the Turkish Medical Association, increases in the current prices of private hospitals and prices of drugs and consumables, new diagnostic and treatment methods and changed costs, overheads, commissions, changes in the age, gender, disease and treatment risk distribution of the portfolio of the insured, factors such as payment periods, interest rates, inflation and exchange rates are taken into account. The criteria affecting the calculation of the standard tariff premiums and the premium can be reviewed and changed when it is deemed necessary. Policy premiums are calculated based on the standard tariff premiums and the tariff model being in effect at the date of inception of the policy.

10.2 - Regulations Concerning the Premium:

* Groupama Sigorta has the right to apply additional premium for loss based on the standard tariff premium in the calculation of the renewal premiums.

* For any disease/disorder of the insured, additional premium for disease within the range of 5 to 50% per disease can be applied.

* If, after determination of the renewal premium, a claim is made under the previous policy and if, as a result of this claim, a change occurs to the renewal premium, the insurer may charge additional premium or terminate the contract.

11 - NEW ENROLLMENT PROCEDURES:

11.1 The upper age limit for the insured for enrollment in the insurance first time ever is 60 at most.

11.2 Pursuant to the law on the “Prevention of Laundering of Crime Proceeds” of 11 October 2006 and the Regulation on Measures for Prevention of Laundering of Crime Proceeds and Financing of Terrorism” published on 9 January 2008 and came in effect on 1 April 2008 pursuant to the law, insurance companies and intermediary entities have been made obliged to identify.

For insurance transactions, when the amount of a transaction or the total amount of two or more transactions connected with each other in relation with the same policy is or above TL 20,000, presentation of the below stated documents to the insurer is the obligation of the policy holder. The documents to be required in this context are:

* *Name and last name of the concerned person*
* *Place and date of birth*
* *Father’s and mother’s name*
* *Nationality*
* *Turkish identity number (for Turkish citizens)*
* *Type and number of the identity document*
* *Address and signature specimen*
* *Telephone number, fax number, electronic mail address, if any, and information about his/her business and profession.*

11.3 The following practices are applicable to children of the insured who were recently given birth and notified to the insurer in writing:

They can be included in the insurance in consideration of a premium calculated on pro rata basis from 14th day of birth at earliest until the end of the insurance term on condition that they are healthy.

Infants to be insured first time ever in conjunction with their parents can be included in the coverage by making a risk assessment from 14th day of birth at earliest.

For applications made after 14th day of birth, the date of enrollment in the policy shall be the date when the application form was received by the insurer.

All family members enrolled in the policy must select the same plan. If the parents are covered by different plans and different policies, the child is covered by the same plan with the plan of the parent together with whom he/she is enrolled in the insurance.

11.4 The premium to be paid for persons enrolled in the insurance during the insurance year shall be calculated on pro rata basis and specified on the endorsement to the policy. Any insured who wants to exit from the insurance during the insurance year must send the cancellation request to the insurer within 7 days following the date specified on the request. If no date has been specified on the request, cancellation shall be made as of the date of receipt of the request by Groupama Sigorta.

12 - TRANSFER AND EARNED RIGHTS:

The rules applicable to insured persons who are included in the health insurance system and changed company during the new insurance term are as follows:

* The insurer is free to grant or not to grant any earned right to an insured person who has policy with another company as a result of a risk assessment. When granting any earned rights to an insured person of the other company, the insurer may request from him/her to submit a declaration stating the recent health condition of the insured, the records regarding social security insurance and/or private health insurance and additional examinations, may obtain information from the Insurance Information Center, previous insurance companies and persons and institutions who and which provided treatment to the insured person and may share any information with the Insurance Information Center. If the insured person fails to fulfill his/her obligation to notify in respect of the health declaration submitted by him/her to Groupama Sigorta or any previous insurance company or companies, any earned rights shall be forfeited.

* In order that any earned rights can be granted, the insured person must have been insured for minimum 1 year under the previous policy and not more than 30 days have elapsed since the expiry date of the insurance. In order that any earned rights are not forfeited, agreement on the conditions and the premium determined as a result of the risk assessment must be reached and the application form submitted to Groupama Sigorta within 30 days. If there is a period of 30 days between the date of the application form submitted to Groupama Sigorta and the expiry date of the policy with the previous insurance company, the inception date of the policy shall be the expiry date of the policy with the other company. However, the person shall be asked to complete a no-claim form for the period between the expiry date of the policy with the other company and the date of issue of the policy by Groupama Sigorta. If more than 30 days have elapsed since the expiry date of the policy with the previous insurance company, the insured person shall be treated as if he/she is a new insured and no earned rights shall be granted to him/her.

* Any rights provided under the special conditions/coverages of the previous policy of the insured but not contained in the special conditions/coverages applicable to the new insurance period shall not be considered as earned rights. However, any rights contained in the special conditions applicable to the new

term but not contained in the special conditions of the previous term shall be applicable to the insured as well.

* The upper age limit for the insured persons who transfer from previous insurance companies to this insurance is 60.

* Any disease of the person which is discovered to exist before the date of the first insurance provided by any previous insurance company does not fall into the scope of earned right, even if an indemnity was paid by the previous insurance company for that disease. Such diseases are excluded from the coverage.

13 - TAXES, DUTIES AND CHARGES:

Taxes, duties and charges levied on the tariff premiums pursuant to the legislation in effect shall be collected from the insured / policy holder.

14 - NOTICE ADDRESS:

If either party changes its address specified in the contract, it is obliged to notify it to the other party in writing. Otherwise notice sent to the previous address shall be deemed valid.

15 - DISPUTES:

Any dispute arising from this insurance shall be settled by Courts and Execution Offices in İstanbul.

16 - TAX BENEFİT:

IN RESPECT OF THE INCOME TAX

* Those who earn income under a payroll (salaried employees)
* Taxpayers who pay income tax by tax return

can deduct the insurance premiums they paid from their income tax base in accordance with the conditions set out in article 63/3 of the Income Tax Law.

17 - TERMS AND CONDITIONS APPLICABLE TO TERMINATION OF THE INSURANCE CONTRACT

If the policy holder requests the cancellation of the health insurance policy before the expiry date of the policy, the following conditions must have been satisfied:

- If a new private health insurance contract covering the period of the residence permit is submitted to the company;
- If the residence permit is cancelled;
- If a document certifying that the insured person has been included in the Public Health Insurance in accordance with the Social Insurance and Public Health Insurance Law No. 5510 is presented.

In addition, such required documents stating the date of exit from the country must be sent to the insurance company.

If the contract is terminated, premium shall be charged on pro rata basis on condition that it is not before the date of the last claim, and cancellation shall be processed.

8 - GENERAL CONDITIONS FOR HEALTH INSURANCE

SCOPE OF OVERAGE
Article 1

This insurance insures against expenses necessarily incurred by insured persons for their treatment if they incur a disease and/or injury as a result of an accident during the term of the policy and against daily indemnity, if any, up to the sums specified on the policy in accordance with these general conditions and, if any, special conditions.

EXCLUSIONS
Article 2

Any disease and/or injury incurred by insured persons as a result of an accident during the insurance term because of any of the following events are excluded from the coverage:

a- War and war-like operations, revolution, insurrection, mutiny and civil commotion arising therefrom;
b- Committing a crime or attempt thereat;
c- Actions of the insured person exposing him/her to a serious danger knowingly, except for an attempt to save and rescue any person and property in danger;
d- Use of illegal drugs such as hashish, heroin, etc.
e- Nuclear risks or use of nuclear, biologic and chemical weapons or an attack and sabotage causing release of nuclear, biologic and chemical substances;
f- Any loss or damage occurred due to biologic and/or chemical pollution, contamination or poisoning caused by acts of terrorism set out in the Anti-Terror Law No. 3713 and sabotage arising from such acts or as a result of interventions of competent authorities to prevent and mitigate impacts of such acts;
g- Any disease or injury caused by suicide attempt of the insured person;
h- Other excluded events specified in the special conditions of the policy.

EXCLUSIONS UNLESS OTHERWISE AGREED
Article 3

Unless otherwise agreed, any disease and/or injury incurred by insured persons as a result of an accident occurred during the term of the insurance because of any of the following events are excluded from the coverage:

a) Earthquake, flood, volcanic eruption and landslide
b) Except for any loss or damage specified in paragraph (f) of article 2, acts of terrorism and sabotage set out in the Anti-Terror Law No. 3713 and interventions of competent authorities to prevent and mitigate impacts of the same.

GEOGRAPHIC LIMIT OF THE INSURANCE
Article 4

Geographic boundaries of the insurance shall be specified on the policy.

INCEPTION AND EXPIRY OF THE INSURANCE
Article 5

Unless otherwise agreed, this insurance shall commence at 12.00 hours noon and end at 12.00 hours noon by Turkish time on the days specified as inception and expiry dates on the policy.

OBLIGATION OF THE POLICY HOLDER TO DECLARE AT THE TIME OF EXECUTION OF THE CONTRACT
Article 6

The insurer has accepted this insurance by relying on the proposal of the policy holder or, in the absence of a proposal, on the written declaration of the policy holder on the policy and its attachments. The policy holder/insured person is obliged to give accurate answers to questions asked to them on the proposal and any documents complementing it and to declare such matters within their knowledge which constitute the subject-matter of the risk and which would influence the appreciation of the risk. If the declaration of the policy holder / insured person is not true or incomplete, in the cases which require that the insurer not to execute the contract or to execute it with heavier conditions,

a- If the policy holder / insured person has done this deliberately, the insurer may withdraw from the contract within one month following becoming aware of it and, if a risk has occurred meanwhile, shall not pay indemnity to the insured person.

In the event of withdrawal, the insurer shall be entitled to receive premium.

b- If the policy holder or the insured person has done this unintentionally, the insurer terminates the contract within 1 month following becoming aware of it or keeps the contract in effect by collecting the premium difference.

If the policy holder or the insured person notifies within 8 days that he/she does not accept the demanded premium difference, the contract terminates. Notice of termination sent by the insurer by registered mail with return confirmation or via a notary public shall become effective at 12.00 hours on the fifth business day following the date of receipt of the notice by the policy holder or the insured person. The premium corresponding to the period until the effective date of the termination shall be calculated on pro rata basis and any surplus premium shall be refunded.

c- The right to withdraw, to terminate or to demand premium difference shall be forfeited if not used within the specified time.

d- In the absence of deliberate act of the policy holder or the insured person,

1- If an insured risk occurs before the insurer has become aware of it or during the period within which the insurer can give notice of termination or during the period before the notice of termination becomes effective, the insurer shall reduce the indemnity in proportion that the charged premium bears to the premium which must be charged.

OBLIGATION TO NOTIFY WITHIN THE TERM OF THE INSURANCE
Article 7

If, after the execution of the contract, any change occurs to such matters as declared on the proposal or, in the absence of a proposal, on the policy and its attachments, the policy holder is obliged to notify the same to the insurer at latest within 8 days.

If such change requires the insurer not to execute the contract or to execute the contract with heavier conditions, the insurer may, within 8 days,

1- Either terminate the contract or
2- Keep the contract in effect by demanding a premium difference.

If the policy holder notifies within 8 days that he/she does not accept the demanded premium difference, the contract terminates.

The notice of termination sent by the insurer by registered mail with return confirmation or via a notary public shall become effective at 12.00 hours on the fifth business day following the date of receipt of the notice by the policy holder.

The premium corresponding to the period until the termination becomes effective shall be calculated on pro rata basis and any surplus premium shall be refunded. The right to terminate or to demand premium difference shall be forfeited if not used within the specified time.

If, after becoming aware of such change, the insurer does not terminate the contract within eight days or acts in such manner to imply that it is contented with the continuance of the insurance contract as it is, such as collecting the insurance premium, then the right of the insurer to terminate the contract or to demand premium difference shall be forfeited.

PAYMENT OF THE INSURANCE PREMIUM, COMMENCEMENT OF THE LIABILITY OF THE INSURER, AND DEFAULT OF THE POLICY HOLDER
Article 8

Whole amount or, if it has been agreed between the parties that the premium be paid in installments, down payment (first installment) of the premium must be paid at the time of execution of the contract or at latest upon delivery of the policy. Unless otherwise agreed, if the whole amount or the down payment of the premium has not been paid, the liability of the insurer shall not commence even if the policy has been delivered and this shall be stated on the face of the policy. If the policy holder fails to pay the insurance premium or the down payment of the premium if payment of the premium in installments has been agreed until the end of the day when the insurance policy has been delivered, the insurance contract shall terminate without notice.

If it has been agreed that liability of the insurer shall commence upon delivery of the policy even if the premium has not been paid, liability of the insurer shall continue during the first fifteen days of this period of one month.

If it has been agreed that the premium shall be paid in installments, due dates and amounts of the installments and the consequences of non-payment of any installment at the respective due date shall be written on the policy or notified to the policy holder in writing in accompany of the policy.

In the event of default in payment of the premium debt, the provisions of the Law of Obligations shall apply.

Providing that it is written on the face of the policy, upon occurrence of an insured risk, the portion of any premium installments which are not yet due and payable which does not exceed the amount of indemnity payable by the insurer shall become immediately due and payable. In the cases where this insurance contract is deemed terminated pursuant to this article, the premium corresponding to the period during which the liability of the insurer continued shall be calculated on pro rata basis and any surplus premium shall be refunded to the policy holder.

UPON OCCURRENCE OF A RISK, OBLIGATIONS OF THE INSURED
Article 9

A - Notification of occurrence of the risk

* The policy holder or the insured person is obliged to notify the occurrence of an insured risk to the insurer in writing within eight days after becoming aware of, or becoming able to notify, the occurrence.

* The policy holder or the insured person is obliged to state the place, date and causes of the accident or the disease on the notice and in addition to obtain a report from the attending physicians about the status and possible consequences of the accident or the disease and send it to the insurer.

B - Commencement of treatment and taking of necessary measures:

It is mandatory to commence the treatment immediately after the accident or the disease and to take the necessary measures for recovery of the injured person or the patient. The insurer has the right to have the victim of the accident or the patient examined and his/her health condition checked at any time, and it is mandatory to give permission for such examinations and checks.
It is mandatory to fulfill the recommendations of the physician of the insurer about the healing of the victim of the accident or the patient which may directly affect the consequences of the accident or the disease.

If the obligations referred in paragraphs (A) and (B) above have not been fulfilled (a) deliberately, the rights arising from the policy are forfeited, and (b) as a result of a fault and if because of this the consequences of the accident or the disease are aggravated, the insurer shall not liable for the aggravated part.
The policy holder or the insured person is obliged to submit originals of such documents stating the examination, treatment, drug and hospital examinations, or copies of them which do not arose any suspicion about their authenticity, in the attachment of the claim and treatment forms of the company which have been completed by the attending physician or the hospital.

DETERMINATION OF EXPENSES
Article 10

This insurance insures the policy holder as well against daily indemnity and expenses if incurred by him/her due to occurrence of a risk insured hereunder up to the limits specified on the policy. The insurer shall not pay any expenses incurred in the following cases:

(a) Any expenses which must not have been incurred due to the nature of the business or any claims made based on a special agreement and in excess of reasonable amount;
(b) Claims for expenses which are in contradiction with the special conditions of the insurance.

If the parties cannot agree on the amount of expenses, the amount of expenses shall be determined by persons called arbitrator-experts who have been appointed by professional organizations of physicians, if any, or among specialist persons in accordance with the following provisions.

(a) If the parties cannot agree on the selection of one arbitrator-expert as per paragraph (b), each party shall appoint its own arbitrator-expert and notify this to the other party via a notary public. The arbitrator-experts appointed by the parties shall appoint a third impartial arbitrator-expert and record this on minutes within seven days following their appointment before commencing to examine the case. The third arbitrator-expert shall be authorized only to render an award on matters not agreed between the arbitrator-experts appointed by the parties to the extent and within the scope that an agreement cannot have been reached. The third arbitrator-expert can render his/her award in a separate report or in the

same report in conjunction with the other arbitrator-experts. Reports of the arbitrator-experts shall be served to the parties simultaneously.

(b) If one of the parties fails to appoint its arbitrator-expert within 15 days following the date of receipt of the notice of the other party or if the arbitrator-experts appointed by the parties cannot reach an agreement on the third arbitrator-expert within seven days, arbitrator-expert of that party or third arbitrator-expert shall be appointed, upon application of one of the parties, by the head of a competent commercial court within the jurisdiction where the treatment has been carried out among impartial and specialist persons.

(c) Each of the parties has the right to demand that the third arbitrator-expert, whether he/she is appointed by the arbitrator-experts of the parties or by the head of a competent court, be appointed from outside the jurisdiction where the insurer or the insured person is domiciled or where the treatment has been carried out and this demand must be fulfilled.

(d) If an arbitrator-expert dies or resigns or is rejected, a new arbitrator-expert shall be appointed in place of him/her in accordance with the same procedure and the proceedings shall resume from where they were left. Death of the insured person shall not terminate the duty of the arbitrator-expert. The right to raise objection against an arbitrator-expert on the grounds of lack of specialty shall be forfeited if not used within seven days after notification of the arbitrator-expert(s).

(e) The arbitrator-experts can demand such evidence, records and documents as they deem necessary to determine the amount of expenses and make an examination at the place of treatment.

(f) Award of the arbitrator-expert(s) or the third arbitrator-expert on the amount of expense shall be final and binding on the parties. Indemnity may not be claimed from the insurer without relying on the award of an arbitrator-expert. Objection can be raised against arbitrator-experts and their awards only if it is found that their award is clearly and materially different from the actual situation and application to a competent commercial court within the jurisdiction where the treatment has been carried out can be made within one week following the date of receipt of the award for cancellation of the award.

(g) Insofar as the parties cannot agree on the amount of indemnity, any sum shall become due and payable only by an award of the arbitrator-expert and the statute of limitations shall not start to count before the date of serving of the final award to the parties, unless two years have elapsed between the date of appointment of the arbitrator-experts and the notification period specified in article 1292 of the Turkish Commercial Code.

(h) The parties shall pay the fee and expenses of their own arbitrator-experts. Fee and expenses of the third arbitrator-expert shall be paid by the parties equally.

(i) Determination of the amount of expense shall not invalidate the terms and conditions set out in this policy and the legislation regarding the covered risks, the insured sum, the insurable value, the commencement of liabilityand the causes for forfeiture or reduction of a right and shall not preclude claiming of the same by either party.

EFFECTS OF PAYMENT OF INDEMNITY AND INSURER'S RIGHT OF SUBROGATION
Article 11

The insurer shall subrogate the insured person on account of the treatment expenses paid by it against responsible third persons up to the amount paid by it.

CO-INSURANCE
Article 12

If the treatment expenses have been insured by more than one insurer, such expenses shall be shared among the insurers in proportion to the sum insured by each of them.

KEEPING OF SECRETS CONFIDENTIAL
Article 13

The insurer is responsible for any loss resulting from not keeping any secret learnt by it about the policy holder or the insured person confidential.

NOTIFICATIONS
Article 14

Notices of the policy holder shall be sent via a notary public or in writing to the head office of the insurance company or the agent who mediated the insurance contract. Notices of the insurance company shall be sent to the address of the policy holder specified on the policy or, if this address has been changed, to the last address notified to the head office of the insurance company or the agent who mediated the insurance contract.

COMPETENT COURT
Article 15

The competent court for any lawsuit filed against the insurance company on account of a dispute arising from this policy shall be a commercial court within the jurisdiction where the head office of the insurance company or the agent who mediated the insurance contract is situated or where the loss or damage has occurred and for any lawsuit filed by the insurance company shall be a commercial court within the jurisdiction where the domicile of the defendant is situated.

TIME BAR
Article 16

All claims arising from the insurance contract are subject to a time bar of two years.

SPECIAL CONDITIONS
Article 17

Special conditions can be specified on the policies which are not in contradiction with these general conditions and, if any, such clauses related with them.