AK PRIVATE HEALTH INSURANCE INFORMATION FORM

AKSigorta
Bambaşka.

This form, which has been drawn up in 2 copies, has been prepared to fulfill the customer notification obligation imposed as per article 1423 of the Turkish Code of Commerce 6102 and the Regulation on the Notification of Clients in Insurance Contracts published in the Official Gazette on 28.10.2007.

A. INFORMATION ABOUT THE INSURER

INSURANCE COMPANY	**AKSİGORTA A.Ş.**
ADDRESS	Poligon Cad. Buyaka 2 Sitesi No:8 Kule:1 Kat:0-6 Ümraniye
PHONE AND FAX NUMBER	(0216) 280 88 88 - (0216) 280 88 00
SALES CHANNEL	
TECHNICAL PERSONNEL NAME & SURNAME	
ADDRESS	
PHONE AND FAX NUMBER	( ) - ( )
PLATE REGISTRATION NO:	

B. WARNINGS

1. For further information about your Insurance Contract / Contracts, please refer to the General Terms and Conditions and the Policy Special Terms prepared by the Insurer.
   Find out more about our products and partner institutions by contacting our sales channel or visiting our web site **www.aksigorta.com.tr**
2. Where an insurance contract has been made, the insurer's liability begins with payment of the whole insurance premium or in the case of payments in installments, with the downpayment.
3. For avoidance of any disputes, please remember to get a payment receipt for your premium payments (in advance or by installments).
4. Premium payment terms agreed between the Policy Holder and the Insurer are immutable. Policy Holders missing their installment payments fall into a payment default and make themselves liable as per article 1434 of the Turkish Code of Commerce. Other rights of the insurer arising from the Turkish Code of Obligations due to the default of the policy holder shall be reserved.
5. As a policy holder, simply click the websen section of the website www.sencard.com.tr to get a password using your TR ID Number and the mobile number registered in the system, view your policy details, review claims payment rules, update personal information and view online your medical examination results.
6. If the Policy Holder / Insured makes a written demand of withdrawal from the policy within the first 30 days as of the policy start date, and if no risk has occured and no claims claims have been made so far, all premiums paid are fully refunded to the Policy Holder.
7. In case of any claims payment have been made after 30 days following the policy start date and/or any claims payments have been already made before withdrawal request, the premium amount to be refunded, is determined by calculating the day-based premium. If the amount of claims payments does not exceed earned premium amount of the insurer; earned premium amount will be deducted from paid premium and the refund to insured. If the amount of claims payments exceed earned premium amount and does not exceed paid premiums; claims payment will be deducted from premiums and refund to insurer. If claims payment exceeds both paid premiums and earned premiums, no premium refund takes place. Realization of a risk causes portion of the undue premium installments not exceeding the compensation amount payable by the insurer to become due.
8. Renewal Guarantee that comes with this Product contains different liabilities to those contained in Article 7 of the Regulation on Private Health Insurance Policies. More detailed information about scope of the Renewal Guarantee given by the Insurer can be found at the Policy Special Conditions booklet prepared by the insurer.
9. Answer all questions in the Application and Declaration Form fully and correctly during drawing up of the contract or in other cases requested by the Insurer. Any circumstances that may change the policy terms and conditions must be notified even though they may not be included in the Application and Declaration Form. Refrain from providing the insurer with wrong or missing information during the contract terms or whilst making claims. Otherwise, as per relevant provisions of the General Terms and Conditions, the Insurer may annul the contract and / or may introduce additional terms (additional premiums, exemption, limit, stanby period etc.).
   If the insured denies the insurance company access to details regarding his past medical history, the contract is then drawn up on the basis of statements of the Insured, the Policy Holder or, the Representative, if the insurance is being taken out via a representative, or on the basis of responses to the written questions of the company. The Insured, the Policy Holder and the Representative, if any, must give correct answers to all questions and notify any known circumstances which would cause the company not to make the contract or make it under more severe circumstances. If need should be, the company may wish to consult a medical expert's opinion for a more precise assessment of the Insured's health condition. All related costs are borne by the Policy Holder and the Insured.

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mim@sencard.com.tr

C. GENERAL INFORMATION

1. COVERAGES

This insurance covers the following items: Policy warrants and warranty amounts, to which shall apply provisions in the special terms in the policy attachment, are stated in your Policy and the attached Coverage Table.

I. HEALTH INSURANCE COVERAGES

The health insurance coverage is intended to cover, under General Terms and Conditions and Policy Special Terms, medical expenses of the insured, at limits and contribution rates stated in the Coverage Table, which may arise during the contract period.

INPATIENT TREATMENT COVERAGE	☐ Unlimited

OUTPATIENT TREATMENT COVERAGE

☐ Unlimited	☐ TL 2,000	☐ TL 3,000	☐ TL 4,000	☐ TL 5,000
☐ Participation Rate	☐ 0	☐ 20		

Advanced Diagnosis Methods	☐ I am interested	☐ I am not interested

OVERSEAS INPATIENT TREATMENT COVERAGE

☐ I am interested	☐ I am not interested
☐ Unlimited	☐ EURO 70,000

OVERSEAS OUTPATIENT TREATMENT COVERAGE

☐ I am interested	☐ I am not interested
☐ TL 5,000	☐ TL 7,500

MEDICAL SERVICE NETWORK SELECTION

☐ Standard	☐ ECO

BIRTH COVERAGE

☐ I am interested			☐ I am not interested	
☐ TL 1,000	☐ TL 2,000	☐ TL 3,500	☐ TL 5,000	☐ TL 7,000

2. EXCLUSIONS

Please refer to the Medical Insurance General Terms and Conditions and the Policy Special Terms and Conditions prepared by the Insurer for the cases out of coverage.
The insurer can determine coverage, coverage limits and base premiums depending on coverages.
No payments are made for conditions stated in the Turkish Code of Commerce, General Terms and Conditions and in the "Out Of Coverage Situations" (standard exceptions and standby period) article in the Special Policy Terms.

3. CRITERIA FOR SETTING PREMIUMS

POLICY PREMIUM

Policy Premium rates are determined by factors such as; age and sex of the insured, any chronic / serious illnesses he/she may have, coverage and coverage limit amount in the scope of policy, coverage type, network, contribution rate, exemption amount, exemption contribution percentage, coverage usage frequency, claims/premium rates, geographical zones and medical inflation.

D. REGULATIONS ON RISK ASSESSMENT AND PREMIUMS

1. As the Insurer make an evaluation, refers to all information provided by the Insured and / or the Policy Holder during the initial contract and refers to claims payments throughout the year and his/her health situation during contract renewal.
   According to research and evaluation of the Insurer, may choose to introduce additional terms (exemption, limit, additional premiums, contribution, stanby period etc.), reject the application or refuse not to renew the contract following his/her evaluation. Please consult your sales channel to find out about the outcome of the assessment.
2. In case of any transitions from other companies, as insured's information details would have sent to insurer from his/her previous insurance company, if s/he was insured minimum for one (1) year, Risk Assessment Unit can assess applicants' health statements and other submitted information for a decision. According to result of evaluation of Risk Assessment Unit, period of insurance from previous insurance company might have been accepted as an insured's earned rights and/or contract terms might have been redefined (exemption, limits, additional premiums, contribution, stanby period, etc) and insurance contract might have been cancelled. However, pregnant candidate will treated as a first year; standby period of Birth Coverage and Pregnancy and Routine Controls Coverage will be applied.

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3. Family discounts are applied where the father, mother and children up to the age of 24 years are covered by the same insurance policy, taking into account the number of persons to be insured.
4. In policies with Birth Coverage which are renewed consecutively, birth costs are already met by our company of new-born babies within one month following discharge from the hospital, in case of adding to policy by filling out a health declaration form, notifying our company and paying premium amount; these new-born babies will be covered by congenital diseases and disabilities. Standby period shall not apply to children with such medical conditions.
5. Providing the expired policy and the policy that came up for renewal contain the same warrants, No claim bonuses / discounts and or additional premiums may be applied under aforementioned conditions and at aforementioned rates during renewal period of the expired contract following assessment of the final year's Paid Compensation / Payable Policy Premium rate.

For policies with Inpatient Treatment Coverage;

C/P RATE	NO CLAIM BONUS RATE
0	10% discount

For policies with Inpatient + Outpatient Treatment Coverage;

C/P RATE	NO CLAIM BONUS RATE	C/P RATE	CLAIMS/ADDITIONAL PREMIUM RATE
0 - 10	40% discount	121 - 150	20% additional premium
11 - 25	25% discount	151 - 200	30% additional premium
26 - 50	10% discount	201 - 250	40% additional premium
51 and above	0% discount	251 and above	50% additional premium

6. In case of any cash in advance payment of all policy premium amount, a cash payment discount is applied. Moreover, in similar situations and in the scope of future campaigns, Insurer may periodically apply other discounts and additional premiums than above.
7. An applicant who provides these circumstances may apply Renewal Assurance; consecutively 3 years insured in an insurance company, first entry age to our insurance company 57 years or younger, by filling an application form and giving all medical history of him/herself. In order to take into account application of Renewal Assurance, last 3 years average Claims/Premium rate must be either 80% or below at the end of the 3 years policy period. The insurer may request applicants to pass a medical examination in order to assess their medical condition. The Insurer's commitment of "Renewal Assurance" differs from the commitment terms set out in the "Life Long Renewal Assurance" in Article 7 of the Regulation 28800 of Private Health Insurance published in the Official Gazette by the Treasury of the Turkish Republic. Scope of the Renewal Assurance provided by the insurer, can be found under Policy Special Terms in the Policy attachment.

E. INDEMNITY PAYMENTS

1. In case of application to a contracted/partner company, the Insurer makes payment for medical treatment expenses directly to partner company in the scope of Coverage Table and agreement between the Insurer and the partner company which is enclosed to Policy and Policy General and Special Conditions.
2. In case of application to uncontracted/non-partner company, medical treatment cost will be initially paid by insured. Claims notifications are assessed following receipt of all necessary documents and data by the Insurer. Claims notifications in scope of Health Policy General Conditions and Policy Special Conditions are paid by the Insurer due to conditions such as; limits, exemptions, contribution share indicated in enclosed Coverage Table.
3. Claimers need to submit all necessary documents to the Insurer to claim their rights arising from the policy. Please ask your Insurer or visit our website for a list of information and documents required for claims payments. In case of any risk realization, please apply to senCard service centre with necessary information and documents to the address and contact details provided in this form.
4. Health expenses in scope of inpatient coverage, length of stay at healthcare institutions is 200 days for an annual insurance period. Normal hospitalization is 1 day and emergency unit hospitalization is calculated as 2 days and deducted from the total length of stay. All expenses from hospitalization at health institutions exceeding the 180 days limit is out of coverage.

F. TAXATION

Premiums paid for health insurance may be deducted from the tax base subject to taxation. Please consult your Insurance Company for more information.

G. ARBITRATION SYSTEM MEMBERSHIP

The insurer is a Member of the Arbitration System.

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H. COMPLAINTS AND INFORMATION REQUESTS

Please use the address, phone number and email address given below for all your complaints and requests. All your requests and complaints are responded in 15 days (if the insurer deems it necessary this period may start at the end of the investigation) in case of contact information not given to insurer, respond will be send to insured to his/her latest contact details where insurer have in its system.

I agree that your company may send messages of information and marketing, sent by SMS, telephone, e-mail and other communication channels.

CONTACT ADDRESS

ADDRESS	**senCard Contact Center** Küçükbakkalköy Mah. Başar Sok. No: 20 34750 Ataşehir - İstanbul
PHONE NO	444 27 27
FAX NO	(0216) 571 55 56
E-MAIL	mim@sencard.com.tr

Policy Holder Title, Stamp/Name, Surname, Signature, Date	Sales Channel Title, Stamp/Name, Surname, Signature, Date
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