New Business Transmittal

Transmittal Date

Mailing Address
Attn: New Business Service Center
John Hancock Life Insurance Company
PO Box 55765
Boston MA 02205-5765

Overnight Courier
Attn: New Business Service Center
John Hancock Life Insurance Company
27 Drydock Ave
Boston MA 02210-2377

Firm

☐ Formal ☐ Informal Query (IQT)

New Business Firm Contact

New Business Firm Contact	Phone Number	Fax Number
E-mail Address	Street Address	
Is this a Wholesaling case? ☐ No ☐ Yes	Broker Dealer	

Producer

Producer Name - First and Last		
SSN	**John Hancock Producer Code**	
In relation to this insurance application, can we contact the Producer directly? ☐ No ☐ Yes	Phone Number	Fax Number

IMPORTANT: To avoid delays in processing this application, please ensure that the producer is properly LICENSED with the applicable John Hancock company in the state where this application is being solicited.

Proposed Insured

Proposed Insured (1) Name	Proposed Insured (2) Name	
In relation to this insurance application, can we contact the Proposed Insured directly? ☐ No ☐ Yes	Phone Number	Best time to call

Attachments – Mark (x)

- ☐ Authorization
- ☐ Cover Letter
- ☐ Non-Med
- ☐ Avocation Questionnaire
- ☐ Signed Proposal
- ☐ Replacement Forms
- ☐ 1035 Forms
- ☐ Temporary Insurance Agreement
- ☐ Premium Check
- ☐ Certified TIN
- ☐ Trust Document
- ☐ Fund Allocation or Policy Detail Form
- ☐ Other (Specifics) _____

Medical Requirements

- ☐ EKG
- ☐ APS
- ☐ TST
- ☐ Para-Med

Outstanding Requirements – Mark items already ordered with (x) and indicate the Service Provider.

- ☐ Authorization
- ☐ Cover Letter
- ☐ Non-Med
- ☐ Avocation Questionnaire
- ☐ Signed Proposal
- ☐ Replacement Forms
- ☐ 1035 Forms
- ☐ Temporary Insurance Agreement
- ☐ Premium Check
- ☐ Certified TIN
- ☐ Trust Document
- ☐ Fund Allocation or Policy Detail Form
- ☐ Other (Specifics) _____

Medical Requirements	Service Provider
☐ Para-Med	
☐ Blood/micro	
☐ EKG/TST	
☐ X-Ray	
☐ APS	

John Hancock's Regional Director Name

Comments/ Special Handling Instructions

John Hancock
the future is yours

Instructions for Application for Life Insurance

This kit is for all John Hancock products (including Long-Term Care Rider), excluding John Hancock New York

Applications for John Hancock New York, Term Conversion and Policy Change may be obtained from **www.jhsalesnet.com** or any other of our producer web sites. Requests for hardcopy forms and COLI applications may be made through any John Hancock regional office.

1. Do You Have the Correct Form?

The application form must be taken in the state where solicitation took place. In most cases, the state of issue will be where the Owner resides and solicitation took place. The following governing principals must always be followed when determining state of issue:

- The application form must be signed in the state where solicitation took place.
- The agent must be licensed in the state where solicitation took place.
- The product must be approved in the state where solicitation took place.
- Policy delivery must be or must be deemed to be in the state where solicitation took place.
- There must be a relationship between the owner and the state of solicitation.

For more details, see 'State selection help' on the New Business Electronic Forms on **www.jhsalesnet.com**.

2. Buyer's Guide

A Buyer's Guide must be given to the Owner at time of the application. A link to the correct Buyer's Guide for the state of solicitation is available on the 'View My Forms' Page when searching for a state specific kit using 'New Business Online Forms'.

3. Employer/Corporate Owned Policies

- If the policy being applied for is employer/corporate owned with an employer/corporate beneficiary, Section 101(j) of the Internal Revenue Code (IRC) may apply.
- Please consult a tax professional prior to submission of the application to ensure compliance and understanding of the notice and consent requirements of section 101(j).

4. Military Personnel Policies

Military Personnel policies are polices where an active duty service member is the Proposed Life Insured or the Owner of a policy on the life of their spouse or children. For these applications, Form **NB5109US** must be submitted. This form is available in the Non Underwriting Forms section of 'View My Forms'.

5. Special Riders/Benefits Instructions

The following benefits/riders have specific instructions that must be followed if the particular benefit/rider is requested

- **Children's Insurance Rider or Applicant Waive**r – Complete Form **NB5020**. This form is part of the application kit if this option is selected.
- **Long-Term Care Rider** – Follow the Long-Term Care Rider kit instructions (following page) to ensure the correct Outline of Coverage is given to the Proposed Life Insured.
- **Accelerated Death Benefit** (for terminal illness) – Provide the **Owner** with the **Disclosure Statement, NB1237**.

Instructions for Long-Term Care Rider

- Complete and submit the **Application Supplement, NB5018**.
- Provide the Proposed Life Insured with:
  - **Notice of Replacement, NB5019**, if other coverage is being replaced.
  - **Notice of Protected Health Information Privacy Practices, NB5059US**.
  - **Guide to Health Insurance for People with Medicare, LTC1014**, if the Proposed Life Insured is age 65 or older. This guide is available on a link on the 'View My Forms' Page when searching for a kit using 'New Business Online Forms'.
- **Outline of Coverage**.

Do You Have the Correct Outline of Coverage?

The Outline of Coverage form is specific to the type of product requested. The following grid has been designed to help determine which form should be provided.

Universal/Variable Life Insurance	Traditional/Term Life Insurance
05OCLTCU or 07OCLTCU	08WLOCLTCU

Taking Care of Tomorrow: A Consumer's Guide to Long-Term Care, LTC-1426 can be obtained by accessing the LTC order system via www.jhltc.com with an order number of LTC-1426 or by contacting the Literature line at 1-800-892-9552.

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Application for Life Insurance

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s) and Owner.

PROPOSED LIFE INSURED(S) LIFE ONE

1. a) Name _____ (First / Middle / Last)

b) Date of Birth ____ ____ ____ (month / day / year) c) Sex ☐ M ☐ F

d) Place of Birth _____ (State / Country)

e) Citizenship ☐ U.S. ☐ Other _____

f) Social Security Number (SSN), if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____ (Address - Street No. & Name / Apt. No.)

_____ (City / State / Zip Code)

i) Years at this Address _____

j) Tel. Nos. _____ (Home / Business)

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.

Secondary Residence _____ (Address - Street No. & Name / Apt. No.)

_____ (City / State / Zip Code)

l) Years at this Address _____

m) Occupation _____

_____ (Name of Employer)

LIFE TWO (Survivorship)

2. a) Name _____ (First / Middle / Last)

b) Date of Birth ____ ____ ____ (month / day / year) c) Sex ☐ M ☐ F

d) Place of Birth _____ (State / Country)

e) Citizenship ☐ U.S. ☐ Other _____

f) Social Security Number (SSN), if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____ (Address - Street No. & Name / Apt. No.)

_____ (City / State / Zip Code)

i) Years at this Address _____

j) Tel. Nos. _____ (Home / Business)

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.

Secondary Residence _____ (Address - Street No. & Name / Apt. No.)

_____ (City / State / Zip Code)

l) Years at this Address _____

m) Occupation _____

_____ (Name of Employer)

OWNER – Complete only if Owner is other than Proposed Life Insured(s)

If Trust Owner, complete questions 3. a), d) and e) and Trust Certification PS5101.

Trust Agreement may be required.

Provide all details as above for other Owner in Special Requests on Page 4.

3. a) Name _____

b) Date of Birth ____ ____ ____ (month / day / year)

c) Relationship to Proposed Life Insured(s) _____

d) Social Security/Tax ID Number, if applicable _____

e) Address _____ (Street No. & Name / Apt. No. / City / State / Zip Code)

4. Multiple Owners

Type of ownership ☐ Joint with right of survivorship ☐ Tenants in common

BENEFICIARY INFORMATION – Subject to change by Owner

List additional beneficiaries in Special Requests on Page 4.

5. a) Name _____ (First / Middle / Last) ☐ Primary _____ (Relationship to Proposed Life Insured(s)) ____ % (Percentage)

b) Name _____ (First / Middle / Last) ☐ Primary ☐ Secondary _____ (Relationship to Proposed Life Insured(s)) ____ % (Percentage)

EXISTING AND PENDING INSURANCE

If more space is required attach additional page that has been signed and dated by Owner if necessary.

6. a) Provide information for each policy in force on the Proposed Life Insured(s) with all companies, including any policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity.

Proposed Life Insured	Company	Insurance		Issue Date	To Remain in Force?		Amount Including Riders
		Personal	Business	month day year	Yes	No	
☐ One ☐ Two		☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐		☐	☐	$

b) Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One ☐ No ☐ Yes – give details _____

Life Two ☐ No ☐ Yes – give details _____

c) Including this application, total insurance currently applied for with all companies (**not including informal inquiries**).
Provide name of Life Insurance Company and amount applied for.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
	$		$
	$		$
	$		$

d) Of the total amount applied for in c) above including this application, what is the maximum that you will accept?

Life One	Life Two
$	$

JUVENILE INSURANCE

Complete e) & f) if juvenile insurance is applied for.

e) Are all siblings equally insured? ☐ Yes ☐ No

f) Amount of life insurance currently in force or pending on parent(s)/guardian(s)? $ _____

If none, provide reason. _____

REPLACEMENTS – OWNER

7. Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums due on the new policy or contract?

☐ Yes ☐ No If **'Yes'**, please complete the **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Standard Form), NB5017.**

FINANCIAL QUESTIONS

Copies of financial statements, estate analyses, contractual agreements may be required.

8. Is there, or are you considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in this application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application?

☐ No ☐ Yes - If 'Yes', provide details _____

9. Have you been offered any money or other considerations by any person or entity in connection with this application?

☐ No ☐ Yes - If 'Yes', provide details _____

10. a) What is the source of the premiums for the policy(ies) currently applied for? _____

b) Will the Owner be receiving funding for the premiums from an individual and/or entity other than the Proposed Life Insured(s) or the Proposed Life Insured's employer?

☐ Yes - If 'Yes', answer question 11 below. ☐ No - If 'No', proceed to question 12.

11. a) Will the premiums be financed through a loan?

☐ No - If 'No' describe the funding arrangement _____

☐ Yes - If 'Yes' provide the loan details in question 11 b), c), d), e) and f) below.

b) What is the annual interest rate? _____ %

c) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?

☐ No ☐ Yes - If 'Yes', provide details _____

FINANCIAL QUESTIONS continued

Copies of financial statements, estate analyses, contractual agreements may be required.

11. d) What is the duration of the loan? _____

e) Who is the lender? _____

f) What amount and type of collateral is required to secure the loan? $ _____ (Amount) _____ (Type of Collateral)

12. a) What is the purpose of this insurance? 0 _____
(e.g. estate conservation, buy-sell, keyperson)

	Life One	Life Two
b) Gross annual earned income (salary, commissions, bonuses, etc.)	$	$
c) Gross annual unearned income (dividends, interest, gross real estate income, etc.)	$	$

d) Household net worth (combined) $ _____

e) In the last 5 years, has the Proposed Life Insured(s) or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? Life One ☐ No ☐ Yes - give details _____

Life Two ☐ No ☐ Yes - give details _____

BUSINESS FINANCIAL QUESTIONS

Complete for ALL Business Insurance.

Copies of financial statements may be required.

	Current Year	Previous Year
13. a) Assets	$	$
b) Liabilities	$	$
c) Gross Sales	$	$
d) Net Income	$	$
e) Fair Market Value of the business	$	$

f) How was the amount applied for determined? _____

g) What percentage of the business is owned by the Proposed Life Insured(s)? _____ %

h) Are other partners/owners/executives insured or applying for life insurance with any company? ☐ No ☐ Yes - give details _____

LIFESTYLE QUESTIONS

Please provide details in No. 18 for 'Yes' answers to Lifestyle Questions.

	Life One	Life Two
14. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
15. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years? If 'Yes', please complete **Aviation Questionnaire NB5009**.	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years? If 'Yes', please complete **Avocation Questionnaire NB5010**.	☐ Yes ☐ No	☐ Yes ☐ No
16. a) Have you been cited for 2 or more moving violations within the last 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you been cited for driving while intoxicated or while otherwise impaired?	☐ Yes ☐ No	☐ Yes ☐ No
17. In the last 10 years, have you been convicted of a felony offense?	☐ Yes ☐ No	☐ Yes ☐ No

18.

Question No.	Life One	Question No.	Life Two

PRIMARY PHYSICIAN – PROPOSED LIFE INSURED(S)

LIFE ONE

19. Provide name and address of primary physician.

Name _____ (First / Middle / Last)

Address _____ (Street No. & Name / Suite No.)

_____ (City / State / Zip Code)

LIFE TWO

20. Provide name and address of primary physician.

Name _____ (First / Middle / Last)

Address _____ (Street No. & Name / Suite No.)

_____ (City / State / Zip Code)

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE

21. a) Date of last visit to ANY doctor/physician _____ (month / day / year)

b) Reason for visit _____

c) Diagnosis or outcome of visit _____

d) Treatment/medication prescribed _____

e) Name of doctor/physician for above (check one)

☐ Primary doctor/physician

☐ Other doctor/physician (provide name and address)

First _____ Middle _____ Last _____

Street No. & Name _____ Suite No. _____

City _____ State _____ Zip Code _____

LIFE TWO

22. a) Date of last visit to ANY doctor/physician _____ (month / day / year)

b) Reason for visit _____

c) Diagnosis or outcome of visit _____

d) Treatment/medication prescribed _____

e) Name of doctor/physician for above (check one)

☐ Primary doctor/physician

☐ Other doctor/physician (provide name and address)

First _____ Middle _____ Last _____

Street No. & Name _____ Suite No. _____

City _____ State _____ Zip Code _____

	Life One	Life Two
23. Has a **John Hancock Medical Exam NB5033** been completed or will it be completed? If 'No', complete question 24 and Medical Certification below.	☐ Yes ☐ No	☐ Yes ☐ No
24. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? If 'Yes', give details below.	☐ Yes ☐ No	☐ Yes ☐ No

Life One:

Product		Frequency	Current	Past	Date Last Used (month / day / year)
Cigarettes	_____	pack(s)/day	☐	☐	_____
Cigars	_____	x /day	☐	☐	_____
Other: _____	_____	x /day	☐	☐	_____

Life Two:

Product		Frequency	Current	Past	Date Last Used (month / day / year)
Cigarettes	_____	pack(s)/day	☐	☐	_____
Cigars	_____	x /day	☐	☐	_____
Other: _____	_____	x /day	☐	☐	_____

MEDICAL CERTIFICATION

Complete this section when submitting a medical examination form of another company in lieu of John Hancock Medical Exam NB5033.

25.

	Name of Proposed Life Insured	Name of Insurance Company	Date of Examination (month / day / year)
1.			
2.			

	Life One	Life Two
a) To the best of your knowledge and belief, is the information in the examination true and complete as of the date this application is signed?	☐ Yes ☐ No	☐ Yes ☐ No

COVERAGE APPLIED FOR

26. Complete the applicable **Coverage Details Form NB5007** (Universal Life), **NB5008** (Variable Life) or **NB5013** (Term & Traditional Life) for details of the policy being applied for, including Supplementary Benefits and other benefit options.

SPECIAL REQUESTS – Attach additional page if more space is required.

TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION

Money may NOT be collected and the **Temporary Life Insurance Receipt and Agreement NB5004** may NOT be issued if:

1. questions 28 and 29 are answered Yes or left blank; or
2. the Proposed Life Insured(s) is under age 20 or over age 70; or
3. the amount applied for is more than $10,000,000 (single life) or $15,000,000 (survivorship).

27. Is coverage being applied for under the Temporary Life Insurance Agreement? ☐ Yes ☐ No
If 'Yes', answer questions 28 and 29.

28. Within the last 24 months, has the Proposed Life Insured(s) under this application:

	Life One	Life Two
a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer?	☐ Yes ☐ No	☐ Yes ☐ No
b) consulted with or scheduled a consultation with a medical professional for any symptoms or medical concerns?	☐ Yes ☐ No	☐ Yes ☐ No
c) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No
d) been declined for life insurance?	☐ Yes ☐ No	☐ Yes ☐ No
29. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?	☐ Yes ☐ No	☐ Yes ☐ No

PRE-AUTHORIZED PAYMENT PLAN

Attach voided sample check.

30. Request for Pre-Authorized Payment Plan

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective month day year	Type of Payment and Amount Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

a) Such checks (which may include withdrawals made electronically) shall be drawn monthly to pay premiums falling due on the designated policies.

b) While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.

c) The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.

d) The first premium paid must be submitted by check.

DECLARATIONS

The Proposed Life Insured(s) and Owner (or Parent or Guardian) declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I/we understand and agree that:

1. The statements and the answers in this application, which include coverage details and any supplemental form relating to health, aviation practices or lifestyle of the Proposed Life Insured(s), will become part of the insurance policy issued as a result of this application.
2. a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that since the date of the application there has been no deterioration in the insurability of the Proposed Life Insured(s), no changes in the lifestyle of the Proposed Life Insured(s), no change in the financial circumstances of the Owner, and nothing has occurred that would require a change to any statement or answer in any part of this application in order to make the statement or answer true and complete as of the date the policy becomes effective. If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage, the policy will not be put into effect, and ii) if there is TIA coverage and the TIA has not ended, the policy will be put into effect but only to the limit of the TIA coverage amount.
   b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurer:
   a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
4. If coverage under a TIA is applied for, I/we have received, read and understand the terms and conditions of the **Temporary Life Insurance Receipt and Agreement NB5004**.

OWNER/TAXPAYER CERTIFICATION QUESTIONS

U.S. Person(s) (including U.S. Resident/Alien(s))
Under the penalties of perjury, I the Owner, certify that:

1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), AND
2. Pick the applicable box:
   - ☐ I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, OR
   - ☐ The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Non U.S. Person(s) and Non Resident Alien(s)
I am providing IRS Form W-8BEN. ☐ Yes ☐ No

AUTHORIZATION TO OBTAIN INFORMATION

I/We, the Proposed Life Insured(s), authorize:

1. The Company to obtain an investigative consumer report on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.) to give The Company and its reinsurers information about me/us or any minor child/children who is/are to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

I/We further authorize The Company to disclose such information and any information developed during its evaluation of this application to:

(a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me/us; (d) me/us; (e) my/our insurance agent, when that agent is seeking insurance coverage through The Company on my/our behalf; or (f) any medical professional designated by me/us.

I/We acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc.

This authorization will be valid for two years from the date of the application shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my/our application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am/We are entitled, or my/our authorized representative is entitled, to a copy of this authorization.

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

Signed at City State This Day of Year

Signature of Owner (Signing Officer please provide title or corporate seal)

X

Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 15)

X

If Proposed Life Insured(s) is under age 15 Parent or Guardian must sign and include relationship.

Signature of Proposed Life Insured Two if other than Owner

X

Agent signature

Signature of Agent/Registered Representative

X

Signed this Day of Year

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Agent Report

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Complete and submit with Application for Life Insurance. Print and use black ink.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

AGENT QUESTIONS

To be completed by the Agent/Registered Representative.

3. a) Total Premium Collected: $ _____ b) Has a Temporary Life Insurance Agreement been issued? ☐ Yes ☐ No
4. a) Question No. 8 of the application asks if there is, or if the applicant is considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in the application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of the application. Examples of such an understanding or agreement include, but are not limited to, arrangements where the proposed Owner has or will have an option to sell to a third party the Owner's interest in the policy, or where a third party has or will have an option to buy the proposed Owner's interest in the policy.
With this understanding, has Question No. 8 been answered appropriately?
☐ Yes ☐ No - give details _____
   b) Will any policy issued on the life of the Proposed Life Insured(s) as a result of this application, replace a policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity? ☐ Yes ☐ No
   c) Will the premiums, now or in the future, be funded by a loan or other means from someone other than the Insured or the Insured's employer? ☐ No ☐ Yes
5. Will any entity other than a life insurance company be medically evaluating the Proposed Life Insured(s) to determine life expectancy or to otherwise obtain financing? ☐ No ☐ Yes - give details _____
6. a) Will this insurance replace existing policies or is the owner considering using funds from existing policies to pay premiums due on the new policy or contract? ☐ Yes ☐ No If Yes, the Agent/Registered Representative is required to present and read **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Standard Form), NB5017** to the Owner. The completed form must be submitted with the Application.
   b) If Accident and Sickness or Long Term Care is being replaced, please give the Proposed Life Insured the **Notice for Replacement of Individual Accident and Sickness or Long-term Care Insurance, NB5019.**
   c) List any other health insurance policies you have sold to the applicant.

Health policies in force	Health policies sold in the past 5 years and no longer in force

7. a) Have you personally met the Proposed Life Insured(s)? ☐ Yes ☐ No - If 'No', answer question 7 b).
   b) Please describe how the application was solicited and completed. _____
8. a) Will this policy be owned by the employer of the Proposed Life Insured(s)? ☐ Yes ☐ No - If 'Yes', answer questions 8 b) & 8 c).
   b) The Proposed Life Insured(s) has received written notice, which: (i) indicates that the employer intends to insure the employee's life; (ii) specifies the maximum face amount for which the employee could be insured at the time the policy is issued; and (iii) informs the insured that the employer will be the beneficiary of the policy. ☐ Yes ☐ No
   c) The Proposed Life Insured(s) has provided written consent to being insured and that such coverage may continue after the employment relationship terminates. ☐ Yes ☐ No
9. Agent Information

Name of Agent/Entity	Agent Code	Social Security No.	Telephone No.	E-mail Address	% Share
					100

Name of Broker Dealer
(if applicable) _____

Total must equal **100%**

CERTIFICATION AND SIGNATURE

Agent/ Registered Representative for this policy must sign this form.

I declare that I have asked the Proposed Life Insured(s) and/or the Owner each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Life Insured(s) which is not fully recorded in this application.

I certify that the state approved Buyer's Guide has been given to the Owner at time of application and that no sales material other than that approved by The Company has been used.

I certify that the following disclosures have been given to the Owner and/or Proposed Life Insured, if they are age 65 and older:

- **Financial Disclosure Notice**
- **Sales Visit Disclosure Notice (at least 24 hours prior to a home visit)**

Signed at City	State	This	Day of	Year

Signature of Agent/Registered Representative

X _____

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Coverage Details – Universal Life

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured(s).
Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s) and/or Owner.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

PREMIUMS

3. Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ List Billed
☐ Pre-Authorized Payment Plan (Please complete either Pre-Authorized Payment Plan Section of the **Application for Life Insurance, NB5000** or **Request for Pre-Authorized Payment Plan, NB5087**)
☐ Other _____

PREMIUM NOTICES AND CORRESPONDENCE

4. Send Premium Notices to: (Select One)
☐ Owner ☐ Proposed Life Insured One ☐ Proposed Life Insured Two
☐ Other _____
Name
_____
Street No. & Name, Apt. No., City, State, Zip Code

5. Send Correspondence to: (Select One)
☐ Same as Above
☐ Other _____
Name
_____
Street No. & Name, Apt. No., City, State, Zip Code

ADDITIONAL INFORMATION

6. If an additional or optional policy is being applied for in a separate application, state plan and amount:
_____ $ _____
Plan Name

7. Do you understand that you may need to pay premiums in addition to Planned Premium if the current policy charges or actual interest credited are different from the assumptions used in your illustration (assuming the requirements of any applicable guaranteed death benefit feature have not been satisfied)? ☐ Yes ☐ No

LIFE INSURANCE QUALIFICATION TEST AND DEATH BENEFIT OPTION

8. Select One: ☐ Guideline Premium ☐ Cash Value Accumulation

Note: Elected test cannot be changed after the policy is issued. You may request an illustration on both tests before making your election.

9. Death Benefit Option: ☐ Option 1 (Face Amount/TFA) ☐ Option 2 (Face Amount/TFA plus Policy Value)

COVERAGE SELECTION

UNIVERSAL LIFE – SINGLE LIFE

☐ **Protection UL-G – Face Amount $** _____

Choose one product from Coverage Selection section.

10. Select the Policy Protection Rider listed in the illustration's Coverage Summary section.
☐ Policy Protection Rider (6% Fixed Loan Rate)
☐ Policy Protection Rider - Enhanced (6% Fixed Loan Rate)
☐ Policy Protection Rider - Flex (6% Fixed Loan Rate)
☐ Policy Protection Rider - Cash Value Advantage (Variable Loan Rate)
☐ Policy Protection Rider - Quick (6% Fixed Loan Rate)

11. Additional Benefits:
☐ Cash Value Enhancement
☐ Disability Payment of Specified Premium:
Monthly Specified Premium Amount $ _____
☐ Return of Premium Death Benefit Rider (with DB1 only)
Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
☐ Accelerated Death Benefit (For terminal illness)
☐ Long-Term Care Rider (Please complete **Application Supplement, NB5018)**
☐ Long-Term Care Continuation Rider
☐ Other _____

COVERAGE SELECTION continued

UNIVERSAL LIFE – SINGLE LIFE continued

Choose one product from Coverage Selection section.

☐ Accumulation UL – Total Face Amount $ _____

12. Base Face Amount (if less than Total Face Amount) $ _____
13. ☐ Supplemental Face Amount (SFA) (Check only one, if desired)
    - ☐ Level SFA of $ _____ for the life of the policy
    - ☐ Initial SFA of $ _____ for the life of the policy

    Increasing by: _____ % or $ _____ per year for _____ policy years (level thereafter)
    - ☐ Customized Increasing Schedule (List by policy year. SFA decreases cannot be scheduled at issue. Please complete **Customized Schedule, NB5064**.)
14. Additional Benefits:
    - ☐ Overloan Protection Rider
    - ☐ Cash Value Enhancement
    - ☐ Enhanced Surrender Value Rider
    - ☐ Total Disability Waiver of Monthly Deductions
    - ☐ Return of Premium Death Benefit Rider (with DB1 only)
      Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
    - ☐ Accelerated Death Benefit (For terminal illness)
    - ☐ Long-Term Care Rider (Please complete **Application Supplement, NB5018)**
      - ☐ Long-Term Care Continuation Rider
    - ☐ Other _____

☐ Performance UL – Face Amount $ _____

15. Additional Benefits:
    - ☐ Cash Value Enhancement
    - ☐ Disability Payment of Specified Premium:
      Monthly Specified Premium Amount $ _____
    - ☐ Return of Premium Death Benefit Rider (with DB1 only)
      Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
    - ☐ Accelerated Death Benefit (For terminal illness)
    - ☐ Long-Term Care Rider (Please complete **Application Supplement, NB5018)**
      - ☐ Long-Term Care Continuation Rider
    - ☐ Other _____

UNIVERSAL LIFE – SURVIVORSHIP LIFE

☐ Protection SUL-G – Face Amount $ _____

16. Select the Policy Protection Rider listed in the illustration's Coverage Summary section.
    ☐ Policy Protection Rider ☐ Policy Protection Rider – Enhanced ☐ Policy Protection Rider – Flex
17. Additional Benefits:
    - ☐ Cash Value Enhancement
    - ☐ Return of Premium Death Benefit Rider (with DB1 only)
      Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
    - ☐ Disability Payment of Specified premium
      Life One – $ _____ Life Two – $ _____
    - ☐ Four Year Term (EPR)
    - ☐ Policy Split option
    - ☐ Other _____

☐ Performance SUL – Face Amount $ _____

18. Additional Benefits:
    - ☐ Cash Value Enhancement
    - ☐ Return of Premium Death Benefit Rider (with DB1 only)
      Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
    - ☐ Four Year Term (EPR)
    - ☐ Policy Split option
    - ☐ Other _____

☐ OTHER

19. Select One:
    ☐ Single Life _____ Face Amount $ _____ ☐ Survivorship Life _____ Face Amount $ _____

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

HIPAA Compliant Authorization for Release of Health-Related Information

John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

PROPOSED LIFE INSURED

1. a) Name _____
First Middle Last

b) Date of Birth _____
month day year

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me (protected health information) to The Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB), and any other entity or person having protected health information about me, to disclose it to The Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any of My Providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information to The Company's affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as the MIB.

This protected health information is to be used or disclosed under this Authorization so that The Company may: 1) underwrite my application for life and/or long term care insurance, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to The Company at the above Service Office address, Attention: Chief Underwriter. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I further understand that if I refuse to sign this Authorization, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I or any authorized representative will receive a copy of this Authorization.

SIGNATURE - Please read the above Authorization before signing this form.

Signed at City State This Day of Year

Signature of Proposed Insured/Patient or Personal Representative

Description of Personal Representative's Authority or Relationship to Patient

X

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

PROPOSED LIFE INSURED (LIFE ONE)

1. a) Name _____ (First / Middle / Last)

b) State of Residence _____ c) Date of Birth ____ (month) ____ (day) ____ (year)

NOTICE - LIFE ONE

To determine your insurability, the Insurer has requested that you provide a sample of your blood, oral fluids or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood, urine or oral fluids test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood, oral fluids or urine abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONSENT

Each Proposed Life Insured must complete a separate Consent form.

I have read and I understand this Notice of Consent For Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle or the submission of oral fluids or urine sample, the testing of that blood, oral fluids or urine sample and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signed at City _____ State _____ This _____ Day of _____ Year _____

Signature of Proposed Life Insured _____

Company Copy - Please provide the Proposed Life Insured with a copy.

(See next page)

HIV ANTIBODY TEST INFORMATION

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have had sexual contacts with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

What are the Symptoms? Most people infected with the AIDS virus have no symptoms and feel well. Some develop symptoms that may include:

- Fever including 'night sweats'
- Weight loss for no known reason
- Swollen lymph glands in the neck, underarm or groin area
- Fatigue or tiredness
- Diarrhea
- White spots or unusual blemishes in the mouth

These symptoms are also symptoms of many other illnesses. They may be symptoms of AIDS only if they are not explained by other illness. Anyone with these symptoms for more than two weeks should see a doctor

The HIV Antibody Test

Before you consent to testing, please read the following important information:

1. a) **'ELISA'** test means an enzyme-linked immunosorbent assay serologic test which has been been licensed by the federal Food and Drug Administration to detect antibodies to the Human Immunodeficiency Virus.
   b) **'Positive ELISA test'** means an ELISA test performed in accordance with the manufacturer's specification which is reactive on an initial testing and on at least one of two additional tests of the same serum or plasma specimen.
   c) **'Western Blot Assay'** means an assay which uses reagents consisting of HIV antigens separated by polyacrylamide gel electrophoresis and then transferred to nitrocellulose paper to detect antibodies to the Human Immunodeficiency Virus.
   d) **Reactive 'Western Blot Assay'** means an assay which is reactive according to the standards of performance and results specified in the manufacturer's federal Food and Drug Administration approved product circular for the 'Western Blot Assay' reagents and laboratory apparatus.
   e) **'HIV antibody test'** means an ELISA test or a Western Blot Assay or both.
2. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, your options for obtaining life and health insurance may be limited. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
3. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
4. **Accuracy**. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
   a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
   b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive result to develop after a person is infected.
5. **Possible Adverse Effects of Test**. A positive test result may cause you significant anxiety. A positive test result may limit your ability to obtain life, health, or disability insurance coverage in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
6. **Disclosure of Results**. A positive test result will be disclosed to you or the physician that you designate.
7. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. Certain disclosures of your test results may occur, however, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a positive result from a blood, oral fluids or urine specimen test may be reported to the Medical Information Bureau, a national insurance data bank, as a nonspecific abnormality determined by the testing of blood, oral fluids or urine specimen.
8. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

AIDS COUNSELLING

California toll free numbers:
1 800 367-AIDS
1 800 922-AIDS AIDS=2437
1 800 590-AIDS

AIDS PROJECT - East Bay
510 834-8181
651 20th St, Oakland, CA 94612

ARIS PROJECT
408 293-2747
1550 Alameda, San Jose, CA

San Francisco AIDS Foundation
415 487-3000
10 United Nations Plaza,
San Francisco, CA 94102

National AIDS Hotline
1 800 342-AIDS English
1 800 344-7432 Spanish
1 800 243-7012 TTY-TDD

AIDS PROJECT - Los Angeles
213 993-1600
1313 Vine, Lost Angeles, CA 90028

Central Valley AIDS Team
209 264-2436
19999 Tuolumne, Ste. 625,
Fresno, CA 93721

Native American AIDS Prevention Center
1 800 283-2437

AIDS Services Foundation of Orange County
714 253-1500
17982 Sky Park Circle, Irvine, CA 92614

Sacramento AIDS Foundation
916 448-2437
1330 21st St, Ste. 100,
Sacramento, CA 95814

Summary and Disclosure Statement for Accelerated Benefit

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Name of Proposed Life Insured	Name of Owner (If other than the Proposed Life Insured)	Policy Number

This disclosure statement provides a brief description of the benefit available under the Accelerated Benefit Rider for an acceleration of your life insurance benefits. The full details of the benefit are included in the actual rider.

Description of the Accelerated Benefit

The Accelerated Benefit Rider provides for the payment of a portion of the death benefit under a life insurance policy to the policy owner if the life insured is terminally ill and has a life expectancy of one year or less. The accelerated benefit can only be paid once under the rider. There is no premium charged for the rider.

Conditions or Occurrences Triggering Payment of the Accelerated Benefit

Payment of the accelerated benefit is triggered by our receipt of written evidence satisfactory to us that the life insured is terminally ill and has a life expectancy of one year or less. Part of the evidence must be a written statement from a licensed medical doctor stating the prognosis for the illness.

Effect on Policy if an Accelerated Benefit is Paid

1. Death Benefit: The death benefit of your policy will be reduced by the accelerated benefit paid, plus one year's interest, plus any administrative expense charge.
2. Cash Value: The cash value of your policy will be reduced. The reduced cash value will be equal to the result of the original cash value multiplied by the death benefit remaining after the accelerated benefit is paid, divided by the death benefit before the accelerated benefit is paid.
3. Policy Debt: If your policy has a loan against it, the policy loan will be reduced by the same proportion as the cash value.
4. Premium: There is no change to the premium payable for your policy.

Receipt of the Accelerated Benefit is intended to qualify for favorable tax treatment under section 101(g)(1)(A) of the Internal Revenue Code of 1986 as amended by Public Law 104-191. However, receipt of the benefit may affect eligibility for Medicaid and certain other public assistance programs. You should consult with your personal tax advisor and social service agencies before you decide to receive the benefit.

I/We acknowledge that I/we have received and read this Summary and Disclosure Statement for the Accelerated Benefit.

Signatures

Signed at	This	Day of	Year

Signature of Agent / Registered Representative
x

Signature of Proposed Life Insured
x

Signature of Owner (If other than Proposed Life Insured)
x

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Notice of Disclosure of Information

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s).

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

INFORMATION EXCHANGE

This brief description of our underwriting process is designed to help you understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others, and your right to learn the nature and substance of that information upon written request.

The purpose of the underwriting process is to make sure that you qualify for life insurance and if so, to establish the proper premium charge for that insurance. The information necessary to evaluate your application is dependent upon your age, the amount of insurance you are applying for, your medical history, your occupation, your avocations and other personal information. Your answers on the application are the principal source of information; however, additional sources of information may be required.

Information you provide will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB will supply such company with the information it may have in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers may also release information given in your application and information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Information for consumers about MIB may be obtained on its website at **www.mib.com**.

INVESTIGATIVE CONSUMER REPORT NOTICE

As part of our normal procedure, an investigative consumer report may be prepared concerning your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

On request to the Chief Underwriter, at the above Service Office address, we will disclose to you whether or not an investigative consumer report was done, the nature and scope of the report, a summary of consumer rights and the name and address of the consumer reporting firm from whom you may request a copy of the report.

INSURANCE INFORMATION PRACTICES

The personal information we obtain about you is confidential and we will not disclose it to other parties without your written authorization except as permitted or required by law. You have the right to access the personal information about you that appears in our files, including any medical record information disclosed within three years of your request, unless that information relates to a claim or a civil or criminal proceeding.

However, we will normally give medical record information only to a licensed physician of your choice. You also have the right to seek correction of information about you that you believe to be inaccurate or incomplete. We will provide you with a more detailed explanation of our information practices and access and correction procedures if you send us a written request. You may do so by writing to the Chief Underwriter at the above Service Office address.

Please provide each Proposed Life Insured with a copy.

Notice of Protected Health Information Privacy Practices

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We Respect Our Customers' Privacy

Respect for our customers' privacy, especially with regard to medical information, has long been highly valued at The Company. The trust of our customers is our most valuable asset, and the reason we are in business. We understand that the proper handling of medical information is critical to earning that trust.

We collect medical information from long-term care and medical insurance customers, and sometimes from their medical providers, to make decisions about issuing coverage, charging premiums, and paying claims. This notice will describe how we may use and disclose this medical information.

We are providing you with this notice in accordance with federal health privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act ("HIPAA"). We have obligations under that law to maintain the privacy of your medical information, which we take very seriously. We are required to:

- provide you with notice of our legal duties and privacy practices regarding your medical information. This notice is to satisfy this duty.
- provide you with a paper copy of this notice upon your request, even if you received it electronically.
- comply with the terms of our privacy notice that is in effect. We reserve the right to change this notice, and such change will apply to all medical information that we maintain. If we make a material change to this notice, we will promptly send a revised notice to all long-term care and medical insurance clients.

It is possible that you have received or will receive additional privacy notices from us. Those notices are provided in accordance with other laws and regulations, and describe our practices with respect to personal and financial information in addition to medical information.

Use and Disclosure of Your Medical Information

Below is a description of ways in which insurance companies, including The Company, are permitted to use and disclose the medical information we receive about you in connection with a long-term care or medical insurance application or policy. The uses and disclosures described below, and those that are incidental to such uses and disclosures, are permitted without a signed authorization from you. We will not use your medical information for any other purpose, or disclose it to any other person, unless we have your signed, written authorization to do so.

Use and disclosure for payment related purposes. We are permitted to use and disclose your medical information for our payment related purposes or those of another insurer, health plan, or health care professional. Examples of our payment related purposes include obtaining premiums, providing reimbursement for health care, or determining or fulfilling our responsibility for coverage and benefits under your insurance policy or certificate.

For example, if you have a John Hancock long-term care insurance policy and present a claim for benefits, we may obtain medical records from your doctor to determine if you are eligible for benefits under the terms of the policy. Among the payment-related uses and disclosures that are permitted are:

- determining eligibility for coverage,
- making claim decisions,
- care coordination activities,
- coordinating benefits with other insurers or payers,
- billing,
- claims management,
- collection activities,
- collecting reinsurance, and
- related health care data processing.

We may also disclose your name, address, date of birth, social security number, payment history, account number, and the name and address of your health care provider(s) and/or health plan to consumer reporting agencies in connection with collection of premiums or reimbursement.

Please give this Notice to the Proposed Life Insured.

For further information regarding this notice or The Company's privacy practices, please call our dedicated privacy line at 1-800-550-3787, Monday through Friday, between the hours of 9 a.m. and 5 p.m. (ET). If you have any product or customer service questions, including those about your policy, please call the Customer Service number listed on your policy or recent statement.

Use and Disclosure of Your Medical Information

Use and disclosure for health insurance operations. We are also permitted to use and disclose your medical information for purposes related to our health insurance operations, or the health insurance operations of another insurer or health plan with which you have coverage or have applied for coverage. Our health insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of a long-term care or medical insurance policy or certificate, or for reinsurance purposes.

For example, when you apply for insurance, we may collect medical information from your doctor to determine if you qualify for insurance.

We may also use and disclose such information:

- to conduct or arrange for medical review, legal services, or auditing, including fraud and abuse detection and compliance programs;
- for business planning and development, such as administration, development or improvement of methods of payment or coverage procedures;
- for business management and general administrative activities such as those that relate to compliance with HIPAA; customer service; providing data analyses for policyholders, plan sponsors or other customers (without disclosing the medical information to them); resolving internal grievances; sale, merger, transfer, or similar activities; or removing identifiers from medical information; or
- to offer an enhancement to or upgrade of your existing coverage.

If you are insured under a group long-term care insurance policy, we may also disclose your medical information to the sponsor of your benefit plan to report claims experience or for audit purposes.

Use and disclosure for public health, government, or similar activities. We are permitted to disclose your medical information as described below, although we anticipate any such disclosure to be quite rare:

- to an authorized public health authority or cooperating foreign government official for public health purposes;
- to a public health or other appropriate government authority authorized to receive reports of child abuse or neglect;
- to a person subject to the jurisdiction of the Food and Drug Administration for purposes related to the quality, safety or effectiveness of FDA-regulated products or activities;
- if authorized by law, to a person who may have been exposed to or at risk of contracting a communicable disease or condition;
- to a government authority when there is reason to suspect abuse, neglect, or domestic violence;
- to a health oversight agency for authorized oversight activities; and
- to a coroner or medical examiner, a funeral director, or for organ or tissue donation purposes.

We may also use or disclose your medical information for judicial or administrative proceedings or for law enforcement purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation or similar purposes.

Disclosure to you, your family, and to health care professionals. If you send us a written request, we will disclose your medical information that we have to you.

We may disclose your medical information to your family member, friend, personal representative, or other individual you identify who is involved in your care or reimbursement for your care, but we will first give you an opportunity to give or withhold your consent, where possible. If you are not available to give your consent to such a disclosure, or in an emergency, we may disclose your medical information that is directly relevant to such person's involvement with your care or payment for such care.

We may also disclose your medical information for the treatment activities of a doctor or other health care professional.

Your Authorization to Use and Disclose Medical Information

We are not permitted to, and will not, use or disclose your medical information in any way that is not mentioned above, unless we have your signed, written authorization to do so. You have the right to revoke in writing at any time an authorization you give to us, but not if we have acted in reliance on the authorization, nor if you provided the authorization in order to obtain your insurance coverage.

Your Rights Regarding Your Medical Information

You have certain rights concerning the medical information we have about you in our records, as described below.

Request Restrictions. You have the right to request that we restrict our use and disclosure of your medical information that otherwise would be permitted for purposes related to payment or our health insurance operations, or to your family, friends or others involved in your care or reimbursement for your care.

We are not required to agree to such a restriction, and a restriction will not apply to disclosures to you or for certain public health or government purposes. If we agree to such a restriction, we will not use or disclose your medical information in violation of it except if you need emergency treatment, in which case we will request that your medical provider not further use or disclose it.

We may terminate the restriction upon your written request or with your agreement, or at our initiative, but only as it affects medical information created or received after we advise you of the termination.

Inspect and Copy. You have the right to inspect and obtain a copy of your medical information maintained in our records, but not psychotherapy notes nor information we compile in anticipation of a claim or legal proceeding.

To make a request, please submit it in writing to the address at the end of this notice. If you would like to specify a particular form or format for the information, we will try to accommodate your request if it can readily be produced in that manner; otherwise, we will provide a paper copy or other form or format that we agree upon. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent.

We have a right to decline your request in limited situations, such as where a doctor or other health care professional has determined that substantial harm could be caused to you or another person by giving your medical information to you. In that situation, you would be given a right to have any such denials reviewed by a health care professional designated by us. In the unlikely event that we decline your request, we will give you a written explanation, and advise you of your rights to pursue a review of our decision.

If we do not maintain the medical information that you request, we will tell you where it is if we know. We will respond to your request for access within 30 days after receiving your request, unless the information is not on our premises or we tell you in writing why we need more time, in which case we will respond within 60 days.

Confidential Communications. You have the right to request that we send your medical information to you at a different location or by a means other than mail.

Any such request should be sent to us in writing to the address at the end of this notice, and should specify an alternative address or other means of contacting you.

Amend. You have the right to request that we amend your medical information in our records if you believe that it is inaccurate or incomplete. To make such a request, please submit it in writing to the address at the end of this notice, giving details of your request and why you are making it. We will respond to your request within 30 days.

If we accept your request, we will amend all appropriate records, and take steps to notify appropriate persons you identify as well as persons we know to have the erroneous medical information.

We may deny your request in certain circumstances, such as if the medical information or record you wish to be amended is accurate and complete, or it was not created by The Company (unless the creator is no longer available), or it relates to an anticipated claim or legal proceeding. In that case, we will tell you in writing why we declined your request, and describe your rights, which include (a) the right to submit a written statement of disagreement (subject to our right to prepare a rebuttal statement that we will give to you), which will become part of our records, and will be included with or summarized for future disclosures of the medical information, (b) the right to request that we provide your request for amendment and our denial with any future disclosures of the medical information, and (c) the right to file a complaint.

Accounting. You have the right to request an accounting of disclosures we made of your medical information, subject to certain exceptions.

To make such a request, please submit it in writing to the address at the end of this notice. We will respond within 60 days unless we tell you in writing why we need more time, in which case we will respond within 90 days.

Contacting Us

We appreciate the value you place on your privacy rights. We want to hear from you if you have any concerns about The Company's commitment to protecting your privacy rights.

To make a request as described in the section entitled "Your Rights Regarding Your Medical Information," please send your request in writing to:

John Hancock
John Hancock Place
P.O. Box 111 Boston MA 02117
Attention: Customer Relations

Be sure to include the following information in your request:

- your full name,
- address,
- date of birth, and
- policy number if you purchased your policy individually or Group number and Reference ID number if you purchased a policy through your employer.

If you believe that your privacy rights have been violated and wish to make a complaint, you may send a written complaint including specific details to the address above. You may also submit a complaint to the United States Secretary of Health and Human Services. You can be assured that you will not be retaliated against by The Company if you file a complaint.

For further information regarding this notice or The Company's privacy practices, please call our dedicated privacy line a**t 1-800-550-3787**, Monday through Friday, between the hours of 9 a.m. and 5 p.m. (ET). If you have any product or customer service questions, including those about your policy, please call the Customer Service number listed on your policy or recent statement.

Effective Date: May 1, 2005

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

IMPORTANT NOTICE:
Replacement of Life Insurance or Annuities (Standard Form)
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

This Important Notice must be read to the Owner. It must be signed by the Owner and the Agent/Registered Representative and a copy of the signed form left with the Owner. This Notice must be submitted with the Application for Life Insurance.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

3. ☐ I do not want this notice read aloud to me. _____ (Owner must initial only if this instruction applies.)
Initials

REPLACEMENT

Complete for all applicable policies to be replaced.

A **REPLACEMENT** occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, borrowed from an existing policy, forfeited, assigned to the replacing insurer, or otherwise terminated.

Please complete the following:

INSURANCE COMPANY _____ **POLICY NUMBER** _____

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

Continue list on another page if you have more than 3 existing policies.

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

Make sure you know the facts. Contact your existing company or its agent/registered representative for information about the old policy. (If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent/registered representative in the sales presentation. Be sure that you are making an informed decision.

AGENT'S STATEMENT

4. The existing policy or contract is being replaced because

REMINDER TO AGENT/REGISTERED REPRESENTATIVE: John Hancock's policy concerning replacement appears in the "Agent's Code of Conduct" and states: The "Replacement" of existing policies should only occur when it is demonstratively in the best interest of the client and in compliance with all applicable state and Company requirements. You must disclose all of the advantages and disadvantages of any replacement. The client must fully understand the financial consequences of this action and, where required by regulation, Company policy or industry practice, consent to it in writing. You must indicate on every application for new coverage whenever a replacement is involved in that sale.

REPLACEMENT ISSUES

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the cost and benefits of your existing policy and the proposed policy. One way to do this is to ask the company or agent that sold you your existing policy to provide you with information concerning your existing policy. This may include an illustration of how your existing policy is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies. You should discuss the following with your agent/registered representative to determine whether replacement or financing your purchase makes sense.

PREMIUMS

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid. You will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY

- If your health has changed since you bought your old policy, the new one could cost you more, or your application could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (Ask your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

COMPARISON OF EXISTING AND PROPOSED POLICY

ALL questions must be answered.

7. In comparison with the existing policy, indicate the appropriate answer to the following questions. On the new policy:

a) Is the guaranteed death benefit higher?	☐ Yes	☐ No	☐ Not applicable
b) Are the guaranteed cash values higher?	☐ Yes	☐ No	☐ Not applicable
c) Is the guaranteed interest rate higher?	☐ Yes	☐ No	☐ Not applicable
d) Is the face amount higher?	☐ Yes	☐ No	☐ Not applicable
e) Is the annual premium lower?	☐ Yes	☐ No	☐ Not applicable
f) Is the loan interest rate lower?	☐ Yes	☐ No	☐ Not applicable
g) Is the underwriting classification more favorable?	☐ Yes	☐ No	☐ Not applicable
h) Will any ownership problems be resolved?	☐ Yes	☐ No	☐ Not applicable
i) Will any beneficiary problems be resolved?	☐ Yes	☐ No	☐ Not applicable

You have a "free-look" period within which to examine the proposed policy. If you are not satisfied, you can return it for a full refund within the period stated in the new policy.

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or you may only be able to purchase it at substantially higher rates.

SIGNATURES

I certify that the information and responses given to the questions in this form are, to the best of my knowledge, accurate.

Signed at City State This Day of Year

Name of Owner (Please print) Signature of Owner

X

Name of Agent/Registered Representative as Witness (Please print) Signature of Agent/Registered Representative as Witness

X

ADDITIONAL OWNERS SIGNATURES IF MULTIPLE OWNERS

If additional Owner signatures required please attach additional page including Owner name, date and signature.

Name of Owner (Please print) Signature of Owner

X month day year

Name of Owner (Please print) Signature of Owner

X month day year

Notice for Replacement of Individual Accident and Sickness or Long-Term Care Insurance

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Proposed Life Insured

Name First Middle Last

According to your application and the information that you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care rider to an individual life insurance policy to be issued by The Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO PROPOSED LIFE BY AGENT, BROKER OR OTHER REPRESENTATIVE: I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all the material medical information on an application may provide a basis for The Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice for Replacement of Individual Accident and Sickness or Long-Term Care Insurance " was delivered to me on mmm dd yyyy

Signed at City State This Day of Year

Signature of Agent/Registered Representative

x

Print name of Agent/Registered Representative

Signature of Proposed Life Insured

x

Please provide the Proposed Life Insured with a copy.

Application Supplement

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

- *This form is part of the Application for Life Insurance for the Proposed Life Insured.*
- *Print and use black ink. Any changes must be initialed by the Proposed Life Insured.*
- *Complete in all cases when electing the Acceleration of Life Insurance Death Benefits for Qualified Long-Term Care Services Rider.*

Proposed Life Insured

Name First Middle Last

Monthly Acceleration Percentage

1. Choose a Monthly Acceleration Percentage (select one only): ☐ 1% ☐ 2% ☐ 4%

Protection Against Unintended Termination

2. I understand that I have the right to designate up to three persons other than myself to receive Notice of Lapse/Termination of this insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a Rider Charge is due and unpaid.

☐ I elect. (complete information below) ☐ I DO NOT elect to designate a person(s) to receive such notice.

Name	Address - Street No. & Name, Apt No., City, State, Zip code
Name	Address - Street No. & Name, Apt No., City, State, Zip code
Name	Address - Street No. & Name, Apt No., City, State, Zip code

Insurance History

3. a) Are you covered by Medicaid? ☐ Yes ☐ No

b) Do you currently have or have you had during the last 12 months another accident and health or long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)? ☐ Yes ☐ No

c) Do you intend to replace any of your long-term care, medical or health coverage with the coverage applied for? ☐ Yes ☐ No

d) Do you have any other life insurance policies currently in force which provide similar long-term care coverage? ☐ Yes ☐ No

Details to "Yes" Answers.

Company	Policy/Certificate No.	Type and Amount of Benefits	Currently Inforce?		Is it Being Replaced?	
			Yes	No	Yes	No
			☐	☐	☐	☐
			☐	☐	☐	☐

Health Questions

4. a) Do you currently use mechanical devices, such as: a wheelchair, walker, crutches, hospital bed, dialysis machine, oxygen, or stairlift? ☐ Yes ☐ No

b) Do you currently need or receive help in doing any of the following: bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence? ☐ Yes ☐ No

c) Do you currently have, or have you ever had a diagnosis for or symptoms of:
   1. Alzheimer's disease, dementia, or organic brain syndrome? ☐ Yes ☐ No
   2. Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease? ☐ Yes ☐ No

d) Within the last 5 years, have you had symptoms of, received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions:
   1. transient ischemic attack, neurological disorders, depression, seizures, tremors, injury due to falls or imbalance, memory loss. ☐ Yes ☐ No
   2. bladder disorders, prostate disorders, disorders of the reproductive organs, liver disorders. ☐ Yes ☐ No
   3. osteoporosis, arthritis, fractures. ☐ Yes ☐ No

e) Within the last 5 years, have you ever been hospitalized or consulted or been treated by a member of the medical profession for any reason not previously stated? ☐ Yes ☐ No

f) Have you ever been confined to a nursing home or a custodial care facility? ☐ Yes ☐ No

g) Have you ever received home health care services? ☐ Yes ☐ No

Health Questions - continued

Details for Yes answers to questions 4. a) - g) inclusive.

Question No.	Date (mmm dd yyyy)	Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Doctor and Hospital

Agreement & Acknowledgment

I agree as follows: I am applying for an Acceleration of Life Insurance Death Benefits for Qualified Long-Term Care Services Rider that will become part of my Life Insurance Policy. I have reviewed the answers and statements in this application. To the best of my knowledge and belief, they are true, complete and have been correctly recorded. They are representations and not warranties. I understand that this application will form the basis of my coverage. Coverage will take effect on the Date of Issue. I also understand that the Rider will only cover myself and will not cover any other person. No other individual may subsequently assume the status of Covered Person under the Rider.

Acknowledgment: I have received the policy Outline of Coverage and a Replacement Notice (if replacement is involved).

Signed at City State This Day of Year

Signature of Agent/Registered Representative

Signature of Proposed Life Insured

x

x

Print name of Agent/Registered Representative

John Hancock

Life Insurance Company (U.S.A.)

John Hancock Place
P.O. Box 717
Boston, Massachusetts 02117

ACCELERATION OF LIFE INSURANCE DEATH BENEFIT FOR QUALIFIED LONG TERM CARE SERVICES RIDER -- FORM 05LTCR
OUTLINE OF COVERAGE

CAUTION. The issuance of this rider is based upon our issuance of the policy and the Life Insured's responses to the questions on the application for this rider. A copy of the application for the policy and the application for this rider is attached to the policy. If the Life Insured's answers are not complete, true, and correctly recorded, we have the right (in addition to any rescission rights described in the contract) to deny benefits or rescind the rider subject to the Time Limit on Certain Defenses provision. The best time to clear up any questions is now, before a claim arises! To contact us, write to: John Hancock Life Insurance Company (U.S.A.), John Hancock Place, P.O. Box 717, Boston, Massachusetts, 02117 or call us at 1-800-543-6415.

1. This rider is attached to an individual life insurance policy

2. **PURPOSE OF OUTLINE OF COVERAGE:**

   This Outline of Coverage provides a very brief description of the important features of the rider. You and the Life Insured should compare this Outline of Coverage to outlines of coverage for other policies or riders available to the Life Insured. This is not an insurance contract, but only a summary of coverage. Only the life insurance policy and rider contain governing contractual provisions. This means that the life insurance policy and rider set forth in detail the rights and obligations of you, the Life Insured, and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY AND RIDER CAREFULLY!

3 **FEDERAL INCOME TAX TREATMENT OF THE RIDER**:

   Long term care insurance was granted favorable federal income tax treatment in the Health Insurance Portability and Accountability Act of 1996 ("Act"). Contracts meeting certain criteria outlined in this Act are eligible for this treatment. To the best of our knowledge, we have designed this rider to meet the requirements of this law. This rider is intended to be a federally tax-qualified long term care insurance contract under Internal Revenue Code section 7702B(b). The benefits provided by the policy are intended to be excludable from federal gross income under sections 7702B and 101(g), as may be amended from time to time. If, in the future, it is determined that this rider does not meet these requirements, we will make reasonable efforts to amend the rider if we are required to do so in order to comply. We will offer you an opportunity to receive these amendments. Charges for this rider may be distributions for income tax purposes. If you have any questions concerning the tax implications of this rider, you should consult with an attorney or qualified tax advisor.

4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED:**

   (a) RENEWABILITY: THIS RIDER IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy and rider, to continue this rider as long as you pay the monthly rider charge when due. In addition, we cannot change any of the terms of the rider without your consent and cannot change the monthly rider charge.

   (b) Total Disability: Waiver of Charges Rider. If the policy contains a Total Disability Waiver of Monthly Deductions rider and we waive monthly deductions on the policy in accordance with that rider, we will waive the deduction for this rider as well.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGE**

   We do not have the right to increase the monthly rider charge as of any rider charge due date.

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND RIDER CHARGES REVERSED**

   (a) THIRTY DAY FREE LOOK. If you are not completely satisfied with the rider for any reason, you may return it within 30 days from the date it was delivered to you. We will then reverse any long term care rider charge imposed, and the rider will be treated as if it had never been issued.

(b) Refund of Unearned Rider Charges. Upon receipt of notice that you have died, we will reverse any long term care rider charge deducted for any period beyond the date of death.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If the Life Insured is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company. Neither the Company nor its agents represent Medicare, the federal government, or any state government.

8. **LONG TERM CARE COVERAGE**

Policies and riders of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home.

The rider provides coverage for actual charges incurred for care up to the Maximum Monthly Benefit Amount for covered long term care expenses, subject to rider limitations and requirements.

9. **LONG TERM CARE ACCELERATED BENEFITS PROVIDED BY THE RIDER**

(a) Covered Services

Subject to the conditions, limitations, and exclusions found in the rider, we will make a monthly Accelerated Benefit payment in an amount not to exceed the lesser of (i) the charges incurred by the Life Insured for Qualified Long Term Care Services, and (ii) the Maximum Monthly Benefit Amount. The monthly benefit will be payable provided we have received evidence satisfactory to us that the Life Insured has incurred charges for Institutional or Non-Institutional Benefits, as described below.

The monthly benefit payment is based upon a Calendar Month time period and the Accelerated Benefit we have approved for that period.

A portion of each approved monthly benefit amount will be used to repay a portion of any Policy Debt under the policy and will reduce the monthly benefit payment for that period.

(b) Institutional Benefits

Institutional Benefits includes receipt of Qualified Long Term Care Services while the Life Insured is confined in a Nursing Home or an Assisted Living Facility and is receiving Nursing Care, Custodial Care, Hospice Care or Respite Care.

(c) Non-Institutional Benefits

Non-Institutional Benefits includes receipt of Qualified Long Term Care Services while the Life Insured is receiving Home Health Care, Hospice Care, or Respite Care in his or her home, a rest home, or in an Adult Day Care Center.

(d) Eligibility for Payment of Benefits

You are eligible for benefit under the rider if the Life Insured:

(i) needs Substantial Assistance, as certified to in writing by a Licensed Health Care Practitioner, to perform at least two of the Activities of Daily Living due to the loss of functional capacity for a period expected to last at least 90 days.; OR

(ii) requires substantial supervision, as certified to in writing by a Licensed Health Care Practitioner, to protect him or herself from threats to health and safety due to the presence of a Cognitive Impairment.

AND

- the 100-day Elimination Period has been satisfied; and
- the Life Insured must receive Qualified Long term Care Services covered under this rider and such services are specified in a Plan of Care; and
- a current Plan of Care and written Proof of Loss for the Life Insured has been submitted to us. (A Plan of Care and written Proof of Loss must be renewed and submitted to us every 12 months, otherwise benefit payments under this rider will discontinue on the first day following the expiry of the 12 month period.)
- we have determined that you are eligible for the payment of benefits under this rider.

"Activities of Daily Living" mean the following activities: Bathing, Continence, Dressing, Eating, Toileting, and Transferring.

"Cognitive Impairment" means a deficiency in a person's short-term or long term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

"Elimination Period" (waiting period) means the number of Dates of Service that would otherwise be covered by this rider, for which we will not pay benefits. The Elimination Period is equal to 100 Dates of Service. Only one complete Elimination Period needs to be satisfied while the policy is in force.

The Elimination Period starts on the first Date of Service. No Date of Service may be counted as more than one day towards the satisfaction of the Elimination Period. The Dates of Service used to satisfy the Elimination Period do not need to be consecutive and may be accumulated under separate claims. We will not pay benefits for charges during the Elimination Period. Days that the Life Insured receives only Respite Care will not count toward the satisfaction of the Elimination Period.

If the Life Insured receives Home Health Care for one or more days in a Calendar Week, we will apply seven days toward the satisfaction of the Elimination Period, except if Respite Care is being received during the Calendar Week. If Respite Care is received during a Calendar Week, only the actual Dates of Service other than Respite Care will be applied toward satisfaction of the Elimination Period. Please note that there will be no credit for days which occurred before the first Date of Service. (Calendar Week means the seven consecutive day period that begins on Sunday at 12:01 a.m.)

10. **LIMITATIONS AND EXCLUSIONS**

In addition to the Conditions set forth above, the following limitations and exclusions apply to this rider.

(a) Exclusions. Qualified Long Term Care Services do not cover care or treatment:

- for intentionally self-inflicted injury;
- required as a result of alcoholism or drug abuse (unless drug abuse was a result of the administration of drugs as part of treatment by a Physician);
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- due to participation in a felony, riot or insurrection;
- for which no charge is normally made in the absence of insurance;
- provided by a member of the Life Insured 's Immediate Family; and
- provided outside the fifty United States and the District of Columbia.

(b) Non-Duplication of Benefits. Qualified Long Term Care Services do not include charges covered under any of the following:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amounts);
- any other governmental program (except Medicaid);
- any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.

(c) Limitations-Charges not Covered. We will not pay for any of the following: Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; durable medical equipment; transportation; and items and services furnished for beautification, comfort, convenience, or entertainment of the Life Insured.

THE RIDER MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS**

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of this rider should be used. ***This rider does not include inflation protection coverage.*** Increases and decreases to the Death Benefit of the policy resulting from the exercise of your rights thereunder, including your right to make policy loans and withdrawals, will cause a change in the Maximum Monthly Benefit Amount and the Death Benefit.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

This rider covers brain disorders with demonstrable organic cause (including Alzheimer's Disease and similar forms of senility and irreversible dementia) that result in the Life Insured's Cognitive Impairment.

13. **LONG TERM CARE RIDER CHARGE**

The monthly rider charge for the long term care rider per 1000 of Net Amount at Risk is shown in the specifications section of the policy.

14. **ADDITIONAL FEATURES; REINSTATEMENT**

(a) Issuance of this coverage may depend upon certain medical information about the Life Insured. This is generally known as medical underwriting.

(b) This rider provides added protection against termination. If this rider terminates while the Life Insured would otherwise meet the eligibility criteria set forth in the provision "Eligibility for the Payment of Benefits", this rider may be reinstated, if you so request, within 5 months of the date of termination if all the following conditions are met:

- the policy is reinstated in accordance with its reinstatement provision;
- you furnish us with satisfactory proof that the Life Insured would have qualified for benefits (if not for the Elimination Period) on the date of termination; and
- all overdue rider charges are paid.

(c) Effect on the Life Insurance Policy.

This rider interacts with the life insurance policy to which it is attached. Each rider benefit payment reduces the Face Amount of the life insurance policy. Each benefit payment also reduces the Policy Value by an amount proportional to the Face Amount reduction. Once benefits are paid under this rider, you will receive a monthly statement showing the amount of benefits paid and the effect of such payments on the policy death benefits, surrender values and policy values, as well as the maximum rider benefits available. Benefits under this rider affect the life insurance policy as follows.

- Withdrawals, Face Amount Reductions, Terminal Illness Accelerated Death Benefit. Any withdrawals, reductions in Face Amount (other than reductions in Face Amount arising solely under the provisions of this rider), or acceleration of the Death Benefit due to Terminal Illness, including those made during a Period of Care under this rider, reduces the Maximum Monthly Benefit Amount, resulting in a new Maximum Monthly Benefit Amount, as determined by us. Such reduction will be effective as of the effective date of the withdrawal, reduction in Face Amount, or acceleration of the Death Benefit. Further, if the policy imposes a charge for a reduction in Face Amount, and a reduction in Face Amount arises solely under the provisions of this rider, such charge will be waived.
- Death Benefit and Face Amount. Each monthly benefit payment reduces the current Face Amount, resulting in a new Face Amount.
- Policy Value. Each Accelerated Benefit amount reduces the current Policy Value, resulting in a new Policy Value.
- Loans. Prior to payment of a monthly Accelerated Benefit payment, a portion of the payment will be used to repay part of any loans under the policy, thus reducing the amount available for long term care expenses.

- Variable Life Insurance Policies. If this rider attaches to a variable life insurance policy, certain restrictions apply to transfers and premium allocations. During each Period of Care, we will automatically transfer any Policy Value in Investment Accounts to the Fixed Account, and no transfer of Policy Value from the Fixed Account to Investment Accounts will be permitted. Further, upon approval of a request for Accelerated Benefits during any given Period of Care, no premium payment may be allocated to any Investment Accounts.

15. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE RIDER.**

John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Health Questionnaire

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured(s).
Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s).

PROPOSED LIFE INSURED(S)

LIFE ONE

1. a) Name _____
First Middle Last

b) Date of Birth _____ _____ _____
month day year

LIFE TWO (Survivorship)

2. a) Name _____
First Middle Last

b) Date of Birth _____ _____ _____
month day year

FAMILY MEDICAL HISTORY

3. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes ☐ No

4. Has any member of your immediate family (parents, brothers, sisters) died of Coronary Artery Disease or Cancer prior to age 60? ☐ Yes ☐ No

5. **LIFE ONE**

	Family History	Age	Give Details of Present State of Health
LIVING	Father		
	Mother		
	Brothers & Sisters		

	Family History	Age	Cause of Death
DECEASED	Father		
	Mother		
	Brothers & Sisters		

6. **LIFE TWO**

	Family History	Age	Give Details of Present State of Health
LIVING	Father		
	Mother		
	Brothers & Sisters		

	Family History	Age	Cause of Death
DECEASED	Father		
	Mother		
	Brothers & Sisters		

HEALTH QUESTIONS

LIFE ONE

7. a) Your Height _____ b) Your Weight _____

c) Have you had any weight change in the past 12 months?
☐ Yes ☐ No - If 'Yes', amount _____ ☐ Loss ☐ Gain

Reason _____

9. a) Name and Address of Personal Physician

First Middle Last

Address - Street No. & Name Suite No.

City State Zip Code

b) Telephone No. _____

c) Date last consulted _____
month day year

Reason and any medication/treatment given _____

LIFE TWO

8. a) Your Height _____ b) Your Weight _____

c) Have you had any weight change in the past 12 months?
☐ Yes ☐ No - If 'Yes', amount _____ ☐ Loss ☐ Gain

Reason _____

10. a) Name and Address of Personal Physician

First Middle Last

Address - Street No. & Name Suite No.

City State Zip Code

b) Telephone No. _____

c) Date last consulted _____
month day year

Reason and any medication/treatment given _____

HEALTH QUESTIONS continued

LIFE ONE

9. d) List by name, address and medical specialty, any Medical Specialists you have been referred to, consulted or treated by in the last 5 years.

e) List any medications (prescription or non-prescription) you are taking currently.

LIFE TWO

10. d) List by name, address and medical specialty, any Medical Specialists you have been referred to, consulted or treated by in the last 5 years.

e) List any medications (prescription or non-prescription) you are taking currently.

Please provide details to 'Yes' answers in questions 16 & 17.

	Life One	Life Two
11. **Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have:**		
a) Chest pain, shortness of breath, heart murmur, high blood pressure, Transient Ischemic Attack (TIA), stroke, irregular heart beat, or any other disease or disorder of the heart or arteries?	☐ Yes ☐ No	☐ Yes ☐ No
b) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?	☐ Yes ☐ No	☐ Yes ☐ No
c) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
d) Arthritis, gout, or any bone, joint, muscle or skin disorder?	☐ Yes ☐ No	☐ Yes ☐ No
e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?	☐ Yes ☐ No	☐ Yes ☐ No
f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?	☐ Yes ☐ No	☐ Yes ☐ No
g) Prostate or testicular disease, disease of the uterus, ovaries or breasts?	☐ Yes ☐ No	☐ Yes ☐ No
h) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?	☐ Yes ☐ No	☐ Yes ☐ No
i) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?	☐ Yes ☐ No	☐ Yes ☐ No
j) Cancer or tumors of any kind, malignant or benign?	☐ Yes ☐ No	☐ Yes ☐ No
k) Any other health impairment or medically treated condition?	☐ Yes ☐ No	☐ Yes ☐ No
12. **Within the last 10 years have you had:**		
a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness or disease?	☐ Yes ☐ No	☐ Yes ☐ No
b) any diagnostic tests, including a treadmill stress test for any purpose, including insurance, whether conducted on an in-patient or out-patient basis?	☐ Yes ☐ No	☐ Yes ☐ No
13. **Within the last 10 years have you** been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No
14. **Within the last 10 years have you:**		
a) used amphetamines, barbiturates, cannabis (marijuana), cocaine, hallucinogens, opiates or any prescription drug except in accordance with physician's instructions?	☐ Yes ☐ No	☐ Yes ☐ No
b) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a support group?	☐ Yes ☐ No	☐ Yes ☐ No
15. **Do you:**		
a) currently have any symptom or medical concern for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed?	☐ Yes ☐ No	☐ Yes ☐ No

15. b) consume alcoholic beverages?

Complete if **Currently** was selected in 15. b)

Complete if **In the past** was selected in 15. b)

Life One	Life Two
☐ Never ☐ Currently ☐ In the past	☐ Never ☐ Currently ☐ In the past
Type of beverage / Frequency / Quantity	Type of beverage / Frequency / Quantity
Date Stopped (month / year)	Date Stopped (month / year)
Reason Stopped	Reason Stopped

DETAILS FOR 'YES' ANSWERS TO HEALTH QUESTIONS

If more space is required, use the Medical Questions Continuation Sheet, NB5034.

16. **LIFE ONE**

Question No.	Date month day year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

17. **LIFE TWO**

Question No.	Date month day year	Reason and Treatment Given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital

SIGNATURES

If the Proposed Life Insured(s) is under age 15, Parent or Guardian must sign and include relationship.

I/We have read the statements and answers in this form and they are complete and true to the best of my/our knowledge and belief. I/We hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at City State This Day of Year

Signature of Agent/Registered Representative

X

Signature of Proposed Life Insured One (Parent or Guardian, if under age 15)

X

Signature of Proposed Life Insured Two

X