Documents Package Prepared for: **Millennium Brokerage Group, LLC**

Prepared Date: **3/5/2012 2:49 PM EST**

Document Name	Description	Expiration Date
NB5000CAKIT_062010	Application for Life Insurance	12/31/2199
NB5005CA	AIDS Notice & Consent	12/31/2199
NB5006US	Notice of Disclosure of Information	12/31/2199
NB5015CA_042011	Authorization to Obtain Information	12/31/2199
NB5025CA	HIPAA Compliant Authorization for Release of ...	12/31/2199
NB1237US	Summary and Disclosure Statement for Accelera...	12/31/2199
NB5017US	Important Notice: Replacement of Life Insuran...	12/31/2199

John Hancock
LIFE INSURANCE

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.
Use the Additional Information/Special Requests section for additional space or special requests if required.

PROPOSED LIFE INSURED LIFE ONE

1. a) Name First Middle Last | b) Sex ☐ M ☐ F

c) Date of Birth Month Day Year | d) Place of Birth State Country | e) Social Security Number

f) Telephone Nos. Personal Business | g) E-mail Address

h) Driver's License No. State | i) Citizenship ☐ US ☐ Other - give details:

j) Primary Residence Street Address City State Zip Code | k) Total years at this address

l) Do you have a secondary residence? ☐ No ☐ Yes - provide address including **zip code and months per year at this address** in Additional Information Q 37.

m) Occupation ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

n) Employer

o) Gross Annual Income Earned $ Unearned $

p) Net Worth $ ☐ Personal ☐ Joint with spouse
Financial Supplement for Personal Insurance NB5125 may be required.

q) Purpose of Insurance ☐ Estate Conservation ☐ Business Insurance - complete Business Insurance section Q 38 ☐ Wealth Transfer ☐ Income Replacement ☐ Other - give details:

r) In the last 5 years, has the Proposed Life Insured or any business of which he/she is a partner/owner/executive been bankrupt, had any liens, judgements or other similar financial difficulties?
☐ No ☐ Yes - give details:

PROPOSED LIFE INSURED LIFE TWO

2. a) Name First Middle Last | b) Sex ☐ M ☐ F

c) Date of Birth Month Day Year | d) Place of Birth State Country | e) Social Security Number

f) Telephone Nos. Personal Business | g) E-mail Address

h) Driver's License No. State | i) Citizenship ☐ US ☐ Other - give details:

j) Primary Residence (if different from Life One) Street Address City State Zip Code | k) Total years at this address

l) Occupation ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed | m) Employer

n) Gross Annual Income Earned $ Unearned $

o) Net Worth (if different from Life One) $ ☐ Personal ☐ Joint with spouse

p) In the last 5 years, has the Proposed Life Insured or any business of which he/she is a partner/owner/executive been bankrupt, had any liens, judgements or other similar financial difficulties?
☐ No ☐ Yes - give details:

OWNER - List additional Owners and details in Additional Information Q 37

3. Who is the Owner? ☐ Proposed Life Insured One ☐ Proposed Life Insured Two ☐ Business Partner
☐ Trust ☐ Trust to be Established ☐ Employer
☐ Other - give relationship to Proposed Life Insured(s) _____

4. If the Owner is a Non US Person or a Non Resident Alien, will the IRS Form W-8BEN be submitted? ☐ Yes ☐ No

Provide details below, if other than Proposed Life Insured(s). If Trust Owner, complete the Trust Certification PS5101. Trust Agreement may be required.

5. a) Name _____ b) Date of Birth/Trust Date Month Day Year

c) Address Street Address _____ City _____ State _____ Zip Code _____

d) Social Security/Tax ID Number (if applicable) _____ e) E-mail Address _____

6. Multiple Owners - Type of Ownership ☐ Joint with right of Survivorship ☐ Tenants in common

BENEFICIARY INFORMATION - Subject to change by Owner. (List additional beneficiaries in Additional Information Q 37)

7. a) Name _____ ☐ Primary Relationship to Proposed Life Insured(s) _____ Percentage _____ %

b) Name _____ ☐ Primary ☐ Secondary Relationship to Proposed Life Insured(s) _____ Percentage _____ %

COVERAGE DETAILS - Refer to your illustration for riders and benefits selected

8. **PRODUCT NAME** _____

9. **FLEXIBLE PREMIUM PRODUCTS**

☐ **Universal Life** ☐ **Variable Universal Life** - complete **Fund Allocation NB5136**

a) ☐ Single Life ☐ Survivorship

b) Base Face Amount $ _____ Supplemental Face Amount $ _____

☐ Level ☐ Increasing by: _____ % for _____ Years

☐ Customized Increasing Schedule - complete **Customized Schedule NB5064**

c) Death Benefit Option ☐ Option 1 (Face Amount/TFA) ☐ Option 2 (Face Amount/TFA plus Policy Value)

d) Life Insurance Qualification Test ☐ Guideline Premium ☐ Cash Value Accumulation

e) **Riders and Benefits** - Refer to instruction page for riders and benefits available per product.

☐ Policy Protection Rider (PPR) ☐ PPR Flex ☐ PPR Quick ☐ PPR Enhanced ☐ PPR Cash Value Advantage

Note: For single life the PPR loan type is fixed except for PPR Cash Value Advantage. For survivorship the PPR loan type is variable.

☐ Extended No Lapse Guarantee
☐ Return of Premium Rider (DB 1 only)
Percentage of premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %
☐ Overloan Protection Rider
☐ Cash Value Enhancement
☐ Accelerated Death Benefit (for terminal illness)

☐ Long-Term Care Rider (complete **NB5018**)
☐ Long-Term Care Continuation Rider
☐ Disability Waiver of Monthly Deductions
☐ Disability Payment of Specified Premium
Monthly Specified Amount $ _____
☐ Estate Preservation Rider (Four Year Term)
☐ Policy Split Option
☐ Other _____

10. **FIXED PREMIUM PRODUCTS**

☐ **Term 10** ☐ **Term 15** ☐ **Term 20** ☐ **Survivorship Term** ☐ **Other** _____

a) Face Amount $ _____

b) Riders and Benefits (if applicable)

☐ Total Disability Waiver
☐ Accelerated Death Benefit (for terminal illness)
☐ Conversion Extension Rider (T15 & T20 only)
☐ Other _____

11. If an additional or optional policy is being applied for by the Owner in a separate application, state plan and face amount.

Plan Name _____ $ _____

PREMIUMS AND FUNDING INFORMATION

12. Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Pre-Authorized Monthly Payment Plan (complete Q 43)
☐ Other _____

13. Do you understand that you may need to pay additional premiums in addition to the Planned Premium if the current policy charges or actual interest credited/investment performance 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 ☐ N/A

14. Send Premium Notices and Correspondence to: (Select One)
☐ Owner ☐ Proposed Life Insured One ☐ Proposed Life Insured Two
☐ Other First Middle Last Relationship to Proposed Life Insured(s)

Street Address City State Zip Code

15. Premium Source
☐ Earned Income ☐ Unearned Income ☐ Loan (complete question 16)
☐ Liquidating Assets - give details: _____
☐ An individual and/or entity other than the Proposed Life Insured's employer - give details:
☐ Settled Contracts - give details: _____
☐ Other - give details: _____

Complete question 16, if premium source is a loan.

16. a) Who is the lender?

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

c) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?
☐ No ☐ Yes - give details: _____

17. 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 - give details: _____

18. Have you been offered any money or other considerations by any person or entity in connection with this application?
☐ No ☐ Yes - give details: _____

EXISTING, REPLACEMENT AND PENDING INFORMATION

If more space is required attach additional page that has been signed by the Owner and Proposed Life Insured(s).

19. 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?
☐ No ☐ Yes - complete state appropriate replacement forms.

20. 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.
If **'None'**, check this box. ☐

Proposed Life Insured	Company	Insurance		Issue Date	To Remain in Force?		1035 Exchange?		Settled or Sold		Face Amount Including Riders
		Personal	Business	Year	Yes	No	Yes	No	Yes	Year	
☐ One ☐ Two		☐	☐		☐	☐	☐	☐	☐		$
☐ One ☐ Two		☐	☐		☐	☐	☐	☐	☐		$
☐ One ☐ Two		☐	☐		☐	☐	☐	☐	☐		$
☐ One ☐ Two		☐	☐		☐	☐	☐	☐	☐		$

EXISTING, REPLACEMENT AND PENDING INFORMATION continued

21. a) If you are applying for life insurance with any other company, provide the amount of all formal applications and name of the life insurance company. **Do not include informal inquiries.**

Proposed Life Insured	Company	Face Amount Including Riders	Proposed Life Insured	Company	Face Amount Including Riders
☐ One ☐ Two		$	☐ One ☐ Two		$
☐ One ☐ Two		$	☐ One ☐ Two		$

b) Total formal coverage pending (including this application) you plan to accept.

Life One $ _____ Life Two $ _____

22. If applying for single life coverage, is there any inforce and applied for coverage on your spouse?

☐ Yes - Total Coverage Amount $ _____ ☐ No ☐ No spouse

23. 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: _____

GENERAL RISK AND LIFESTYLE QUESTIONS - Provide details in Q 32 for 'Yes' answers.

	Life One	Life Two
24. Do you engage in any regular exercise? (ie walking, treadmill, swimming, aerobics, strength training, cycling, yoga) If **'Yes'**, give details of type, frequency and length of time in Q 32.	☐ No ☐ Yes	☐ No ☐ Yes
25. 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 of type of nicotine product, amount and frequency and date last used in Q 32.	☐ No ☐ Yes	☐ No ☐ Yes
26. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? If **'Yes'** give details of location (city/country), purpose, frequency and duration in Q 32.	☐ No ☐ Yes	☐ No ☐ Yes
27. 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'**, complete **Aviation Questionnaire NB5009.**	☐ No ☐ Yes	☐ No ☐ Yes
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'**, complete appropriate **Avocation Questionnaire.**	☐ No ☐ Yes	☐ No ☐ Yes
28. a) Have you been cited for one or more moving violations within the last 2 years?	☐ No ☐ Yes	☐ No ☐ Yes
b) Have you been cited for driving while intoxicated or while otherwise impaired?	☐ No ☐ Yes	☐ No ☐ Yes
29. Have you ever been arrested, convicted, or imprisoned for a felony and/or currently awaiting trial for any crime and/or felony? If **'Yes'** give details of type, date, city/state of felony and/or crime and if currently on probation or parole in Q 32.	☐ No ☐ Yes	☐ No ☐ Yes
30. Have any of your immediate family members (parents, brothers or sisters) died from coronary artery disease or cancer, prior to age 60?	☐ No ☐ Yes	☐ No ☐ Yes
31. Are you a member of the armed forces, including the reserves? If **'Yes'**, complete **Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109.**	☐ No ☐ Yes	☐ No ☐ Yes

32. Details for **'Yes'** answers for questions 24 - 31.

Question No.	Life One	Question No.	Life Two

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE	LIFE TWO
33. a) Date of last visit to ANY doctor/physician Month Day Year	34. a) Date of last visit to ANY doctor/physician Month Day Year
b) Reason for and outcome of visit (Diagnosis / Treatment / Medication Prescribed)	b) Reason for and outcome of visit (Diagnosis / Treatment / Medication Prescribed)
c) Physician Name, Address and Telephone Number	c) Physician Name, Address and Telephone Number
d) Provide Primary Physician name and contact information, if different from 33 c).	d) Provide Primary Physician name and contact information, if different from 34 c).

MEDICAL CERTIFICATION

	Life One	Life Two
35. Have you completed a life insurance para/medical examination? If **'Yes'**, complete chart below and Q 36. If **'No'**, proceed to Q 37.	☐ No ☐ Yes	☐ No ☐ Yes

Proposed Life Insured	John Hancock Exam **OR**	Other Company's Exam	Name of Other Insurance Company	Date of Examination month year
☐ One ☐ Two	☐	☐		
☐ One ☐ Two	☐	☐		

	Life One	Life Two
36. Have you had any illness, injury, operation or treatment, or has there been any change in your health since the date of the examination? If **'Yes'**, give details in Additional Information/Special Requests Q 37.	☐ No ☐ Yes	☐ No ☐ Yes

ADDITIONAL INFORMATION/SPECIAL REQUESTS - Attach additional signed page if more space is required.

37.

COMPLETE THE FOLLOWING SECTIONS ONLY IF APPLICABLE TO YOUR APPLICATION

BUSINESS INSURANCE - Complete if face amount is under $1,000,000. For face amounts $1,000,000 and over complete the Financial Supplement for Business Insurance NB5124.

38. a) Business Insurance Purpose ☐ Key Person ☐ Buy Sell ☐ Business Loan ☐ Other

	Assets	Liabilities	Gross Sales	Net Income	Fair Market Value of the Business
Current Year	$	$	$	$	$
Previous Year	$	$	$	$	$

b) How was the amount applied for determined?

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

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

JUVENILE INSURANCE - Complete if Proposed Life Insured is under age 18.

39. a) Are all siblings equally insured? ☐ No ☐ Yes
If **'No'**, give details:

b) Amount of life insurance currently in force or pending for

	Amount	If none, provide reason
Mother	$	
Father	$	
Guardian	$	

TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION ☐ Not Applicable

Complete this section only if applying for Temporary Life Insurance and the criteria is met.

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

1. questions 40 to 42 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).

	Life One	Life Two
40. Within the last 24 months, has the Proposed Life Insured(s) under this application:		
a) consulted a medical professional for, 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?	☐ No ☐ Yes	☐ No ☐ Yes
b) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?	☐ No ☐ Yes	☐ No ☐ Yes
c) been declined for life insurance?	☐ No ☐ Yes	☐ No ☐ Yes
41. Other than planned routine check-ups, are there medical concerns or symptoms for which a medical professional has not yet been consulted?	☐ No ☐ Yes	☐ No ☐ Yes
42. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?	☐ No ☐ Yes	☐ No ☐ Yes

PRE-AUTHORIZED PAYMENT PLAN - To be completed by Owner ☐ Not Applicable

43. Request for Pre-Authorized Payment Plan ☐ Yes

By selecting **'Yes'**, 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 this policy or any policies subsequently designated.

Checking Account No. _____ Routing No. _____

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.**

Attach voided sample check.

Attach Voided Check here

READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

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 to the best of their knowledge and belief.
In addition, I understand and agree that:

1. **Policy Application:** The statements and answers in this application, which include 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. **Policy Effective Date:**
   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 to the Owner, provided that: (i) there has been no change in health or change in the lifestyle of the Proposed Life Insured(s), (ii) there has been no change in the financial circumstances of the Owner or the Proposed Life Insured(s), and (iii) nothing else has occurred that would require a change in any statement or answer in any part of the application, including any supplemental forms, in order to make the statement or answer true and complete, to the best of the knowledge and belief of the Owner and the Proposed Life Insured(s), as of the date this policy becomes effective. If there has been a change in health: (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 under the TIA and according to its terms.
3. **Employer Owned Policies:** The Proposed Life Insured(s) confirms that they have received, prior to issue, written notice that indicates: a) the employer's intent to insure the Proposed Life Insured(s), (b) the maximum amount of the insurance to be issued on the life of the Proposed Life Insured(s) and c) that the employer will be the beneficiary of the new policy.
   The Proposed Life Insured(s) also confirms that they have provided written consent to being insured and that such coverage may continue after employment terminates.
4. **Fraud Warning:** 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.
5. **Variable Policies:** I/We acknowledge receipt of the current prospectuses and supplements that describe the variable life insurance policy applied for and the sub-accounts of the separate account that are available under this policy. I/We have reviewed the prospectuses and supplements and believe that the variable life policy is consistent with my/our insurance needs, investment objectives and investment risk tolerance.
6. **Temporary Insurance Coverage:** If coverage under a TIA is applied for, I have received, read and understand the terms and conditions of the **Temporary Life Insurance Receipt and Agreement NB5004.**

AUTHORIZATION TO OBTAIN INFORMATION

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

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company or the MIB, Inc. to give The Company and its reinsurers information about me/us or any minor child/children who 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.
3. Any financial professional, CPA, attorney or personal banker to give The Company and its reinsurers financial/net worth information about me/us.

I/We authorize The Company to disclose such information and any information developed during its evaluation of my/our 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 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 - If Proposed Life Insured(s) is under age 15, Parent or Guardian must sign and include relationship.

X

Signature of Owner (Provide title or corporate seal, if Signing Officer)

Owner - Signed at	City	State	This	Day of	Year

X

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

X

Signature of Proposed Life Insured Two if other than Owner

AGENT SIGNATURE

I certify that all the information supplied by the Proposed Life Insured(s) and Owner has truly and accurately been recorded on the application.

X

Signature of Agent/Registered Representative | Date

John Hancock
LIFE INSURANCE

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)

Print and use black ink. To be completed by the Agent/Registered Representative and submitted with Application for Life Insurance.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____

LIFE TWO

2. Name _____

GENERAL INFORMATION

3. a) Total Premium Collected: $ _____ b) Has a Temporary Life Insurance Agreement been issued? ☐ Yes ☐ No

4. a) Is there or is the applicant 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.
☐ Yes ☐ No If **'Yes'**, 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 Proposed Life Insured or the Proposed Life Insured's employer? ☐ Yes ☐ No

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? ☐ Yes ☐ No If **'Yes'**, give details

_____

6. a) Have you personally met the Proposed Life Insured(s)? ☐ Yes ☐ No If **'No'**, answer question 6 b).

b) Describe how the application was solicited and completed.

_____

EMPLOYER OWNED POLICIES

7. a) Will this policy be owned by the employer of the Proposed Life Insured(s)? ☐ Yes ☐ No If **'Yes'**, answer questions 7 b) & 7 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 Proposed Life Insured(s) 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

EXISTING AND REPLACING INSURANCE

8. 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.
- 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.**

b) 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

AGENT INFORMATION - Select only one servicing agent

Where an entity is indicated in the credit line, also include the writing agent information in the chart below.

9. a)

Name of Agent/Entity			BGA/Firm		Agent Code
% Share	Servicing Agent	Social Security No.	Telephone No.	E-mail Address	
%	☐ Yes				

b)

Name of Agent/Entity			BGA/Firm		Agent Code
% Share	Servicing Agent	Social Security No.	Telephone No.	E-mail Address	
%	☐ Yes				

c)

Name of Agent/Entity			BGA/Firm		Agent Code
% Share	Servicing Agent	Social Security No.	Telephone No.	E-mail Address	
%	☐ Yes				

10. Name of Broker Dealer/
Wholesaler (if applicable) _____

CERTIFICATION AND SIGNATURE - An Agent/Registered Representative for this policy must sign this form.

I know of nothing affecting the insurability of the Proposed Life Insured(s) which is not fully recorded in the application submitted on the Proposed Life Insured(s).

I certify that the state approved Buyer's Guide, Notice of Disclosure of Information and any other disclosure notice, statement or information required by state or federal law were given to the Owner at the time of the 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)**

X _____

Signature of Agent/Registered Representative

_____ _____

Signed this Day of Year

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

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 TWO)

2. a) Name _____
First Middle Last

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

NOTICE - LIFE TWO

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.

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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

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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.

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   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.
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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

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.

John Hancock
LIFE INSURANCE

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

Authorization to Obtain 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 LIFE ONE

Name	First	Middle	Last

PROPOSED LIFE INSURED LIFE TWO

Name	First	Middle	Last

AUTHORIZATION TO OBTAIN INFORMATION

I/We, the Proposed Life Insured, authorize:

1. John Hancock Life Insurance Company (U.S.A.) (hereinafter referred to as The Company) to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company or the MIB, Inc. to give The Company and its reinsurers information about me/us or any minor child/children who 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.
3. Any financial professional, CPA, attorney or personal banker to give The Company and its reinsurers financial/net worth information about me/us.

I/We authorize The Company to disclose such information and any information developed during its evaluation of my/our 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 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 - If Proposed Life Insured(s) is under age 15, Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year

X

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

X

Signature of Proposed Life Insured Two

X

Signature of Agent/Registered Representative

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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

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

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