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

Prepared Date: **1/14/2013 11:06 AM EST**

Document Name	Description	Expiration Date
NB5000CAKIT_012013	Application	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_Life1_0320...	HIPAA Compliant Authorization for Release of ...	12/31/2199
NB1237US	Summary and Disclosure Statement for Accelera...	12/31/2199
NB5018US_012010	Long Term Care Long-Term Care Rider Applicati...	12/31/2199
NB5087US_092011	Request for Pre-Authorization Payment Plan - ...	12/31/2199
NB5147CA_022010	Life Insurance Sales Visit Disclosure for Sen...	12/31/2199
NB5017US	Important Notice: Replacement of Life Insuran...	12/31/2199
NB5019CA_072009	Notice of Replacement of Individual Accident ...	12/31/2199
05OCLTCU_US	Acceleration Of Life Insurance Death Benefit ...	12/31/2199
NB5035US_082012	External 1035 Exchange	12/31/2199

John Hancock
LIFE INSURANCE

Service Office:
Life New Business
27 Drydock Ave
Boston MA 02210-2377

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 ☐ Non US Country of Citizenship / Type of US VISA

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 34.

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 35 ☐ 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 ☐ Non US Country of Citizenship / Type of US VISA

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 34

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 34)

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** - If applying for Indexed UL - complete Premium Allocation Instructions **NB5176**

☐ **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**

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 ☐ Monthly (Pre-Authorized Payment Plan only)
☐ Direct ☐ Pre-Authorized Payment Plan - complete Request for Pre-Authorized Payment Plan **NB5087**

13. a) 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

b) **Secondary Addressee(s)** - The Company is required to also mail lapse notices for overdue premiums to any Secondary Addressee(s) you designate in writing. If you wish to designate one or more additional persons to receive notices, provide the following information. You have the right to designate or change a Secondary Addressee at any subsequent time. If you need additional space, complete the Additional Information/Special Requests Q 34 and identify such persons as Secondary Addressee(s).

Name

Street Address, City, State, Zip Code Telephone Number

14. Premium Source
☐ Earned Income ☐ Unearned Income ☐ Loan (complete question 15)
☐ 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 15, if premium source is a loan.

15. 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:

16. 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:

17. 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).

18. 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.

19. 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

20. 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 $ _____

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

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

22. 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 31 for 'Yes' answers.

	Life One	Life Two
23. 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 31.	☐ No ☐ Yes	☐ No ☐ Yes
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 of type of nicotine product, amount and frequency and date last used in Q 31.	☐ No ☐ Yes	☐ No ☐ Yes
25. 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 31.	☐ No ☐ Yes	☐ No ☐ Yes
26. 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
27. 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
28. 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 31.	☐ No ☐ Yes	☐ No ☐ Yes
29. 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
30. 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

31. Details for **'Yes'** answers for questions 23 - 30.

Question No.	Life One	Question No.	Life Two

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE	LIFE TWO
32. a) Date of last visit to ANY doctor/physician Month Day Year	33. 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 32 c).	d) Provide Primary Physician name and contact information, if different from 33 c).

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

34.

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.

35. 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.

36. 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 37 to 39 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
37. 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
38. 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
39. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?	☐ No ☐ Yes	☐ No ☐ Yes

READ THE FOLLOWING CAREFULLY

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. **Flexible Premium Policies**: I/We understand that I/We may need to pay additional premiums in addition to the Planned Premium if the current policy charges or actual interest rate credited/investment performance are different from the assumptions used in the illustration (assuming the requirements of any applicable guaranteed death benefit feature have not been satisfied).
7. **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.**

READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

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
27 Drydock Ave
Boston MA 02210-2377

Beneficiary Designation Supplement

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. List additional beneficiaries on a separate form, if required.

OWNER INFORMATION

1. a) Name of Owner(s)	b) Phone Number

BENEFICIARY INFORMATION

2. a) Name ☐ Primary ☐ Secondary

b) Date of Birth (Month Day Year)	c) Social Security Number	d) Phone Number

e) Address — Street Address | City | State | Zip Code

3. a) Name ☐ Primary ☐ Secondary

b) Date of Birth (Month Day Year)	c) Social Security Number	d) Phone Number

e) Address — Street Address | City | State | Zip Code

4. a) Name ☐ Primary ☐ Secondary

b) Date of Birth (Month Day Year)	c) Social Security Number	d) Phone Number

e) Address — Street Address | City | State | Zip Code

5. a) Name ☐ Primary ☐ Secondary

b) Date of Birth (Month Day Year)	c) Social Security Number	d) Phone Number

e) Address — Street Address | City | State | Zip Code

SIGNATURE

Signed at City State This Day of Year

X

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

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.

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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

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1 800 590-AIDS

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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

John Hancock
the future is yours

Service Office:
Life New Business
27 Drydock Ave
Boston MA 02210-2377

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 genetic information and genetic test results. Further, protected health information includes information on the diagnosis and treatment of mental illness and 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

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

Service Office:
Life New Business
27 Drydock Ave
Boston MA 02210-2377
Fax: 416-926-5599

Request for Pre-Authorized Payment Plan
John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

1. Policy Number (if available) _____

Proposed Life Insured - Life One

2. a) Name First Middle Last

Proposed Life Insured - Life Two

b) Name First Middle Last

Owner - if other than Proposed Life Insured(s)

3. Name First Middle Last

Pre-Authorized Payment Plan Options

4. a) ☐ All Premium Payments (including initial premium) ☐ Subsequent Premiums (Initial premium by check)

b) Frequency ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Planned Premium

c) Amount $ _____

Pre-Authorized Payment Banking Information - Please attach copy of Void Check

5. a) Name of Bank Account Owner(s)

b) Relationship to Policyowner/Relationship to Life Insured

c) Name of Financial Institution

d) Account Owner Type ☐ Individual ☐ Trust ☐ Corporate ☐ Other _____

e) Type of Account ☐ Saving ☐ Checking

Signature(s) - If the Bank Account Owner is a company or trust, an authorized officer must sign stating title and affixing seal or stamp.

I hereby authorize and request The Company to draw checks, which may include withdrawals made electronically, on my account to pay premiums on this policy or any policies subsequently designated.
I understand and agree that:

a) The initial planned premium payment, if paid through the Pre-Authorized Payment Plan, will be withdrawn at policy issue.
b) Such checks, which may include withdrawals made electronically, shall be drawn to pay planned premiums falling due on the designated policies.
c) For a new policy, depending on the selected frequency and the effective date, the required draft amount may differ from the amount indicated above.
d) While the Pre-Authorized Payment Plan is in effect, The Company will not provide notices of planned premiums falling due on such policies.
e) The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Policyowner. If the Pre-Authorized plan is terminated, planned premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
f) I understand that any changes to existing draft information must be submitted at least two weeks prior to the next scheduled draft date.
g) By signing this form I confirm the accuracy and validity of the banking information provided for the requested automated draft process.

Signed at City/State _____ Date _____

Name of Bank Account Owner(s) _____ Signature of Bank Account Owner(s) x _____

Name of Bank Account Owner(s) _____ Signature of Bank Account Owner(s) x _____

John Hancock
the future is yours

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

Life Insurance Sales Visit Disclosure for Seniors Age 65 and Older

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

As a senior resident of the state of California, you should receive this notice no less than 24 hours prior to an initial meeting in your home with your agent/registered representative.

Appointment date and time _____ / _____ / _____ _____ am/pm
month day year Time

Date form mailed/delivered to Proposed Owner/Life Insured(s) _____ / _____ / _____
month day year

- During this visit or a follow-up visit, you will be given a sales presentation on the following subject(s):
  - ☐ Life Insurance
  - ☐ Other insurance products (specify) _____
- You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.
- You have the right to end the meeting at any time.
- You have the right to contact the California Department of Insurance for information or to file a complaint. The consumer assistance telephone number is **1-800-927-4357**.
- The following individuals will be coming to your home:

Name	California License No.
Name	California License No.
Name	California License No.

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 to Applicant Regarding 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

Policy No

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 John Hancock Life Insurance Company (U.S.A.). Your new coverage provides thirty (30) days within which you may decide, without cost, whether you desire to keep the coverage. 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 coverage.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new coverage. This could result in denial or delay in payment of benefits under the new coverage, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. 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.
3. If, after due consideration, you still wish to terminate your present coverage 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 coverage 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 "Notice to Applicant" was delivered to me on: mmm | dd | yyyy

Applicant's Signature _____

COMPARISON TO YOUR CURRENT COVERAGE:

I have reviewed your current long term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums. .
- ☐ Additional or different benefits (please specify) _____
- ☐ Other (please specify) _____

Signed at City State This Day of Year

Signature of Applicant

Print name of Applicant

x

Signature of Agent/Registered Representative

Print name of Agent/Registered Representative

x

Please provide the Proposed Life Insured with a copy.

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
LIFE INSURANCE

Service Office:
Life New Business
27 Drydock Ave
Boston MA 02210-2377

EXTERNAL 1035 Exchange
Absolute Assignment/Beneficiary Change
John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

EXISTING POLICY(IES)
PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

3. Existing Policy(ies) issued by _____
Company Name

LIFE TWO

2. Name _____
First Middle Last

Complete one form per Issuing Company and Owner.

Confirm original policy has been lost or destroyed.

If trust owned, provide full name of trust and name(s) of trustee(s), including date of trust.

Proposed Life Insured		Policy Number	Policy Lost or Destroyed		Owner	Is there a loan on the existing policy?		If 'Yes' do you wish to transfer the loan?	
Life One	Life Two		Yes	No		Yes	No	Yes	No
☐	☐		☐	☐		☐	☐	☐	☐
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EXCHANGES TO NEW POLICY

WHEREAS the undersigned desires to exchange the above referenced Existing Policy(ies) under Section 1035 of the Internal Revenue Code, NOW THEREFORE, in consideration for The Company agreeing to issue a new policy (the "New Policy") in exchange for the Existing Policy(ies),

1. Upon final approval of the undersigned's application for the New Policy, the undersigned:
   a) Assigns and transfers absolutely all right, title and interest in the above referenced Existing Policy(ies) to:
      John Hancock Life Insurance Company (U.S.A.)
      PO Box 55765
      Boston MA 02205-5765
      Attention: LIFE NEW BUSINESS
   b) Authorizes The Company to file this Absolute Assignment / Beneficiary Change with the Existing Insurer, and do everything that is required to accomplish the surrender of the Existing Policy(ies) for the cash surrender value.
   c) Names The Company as beneficiary under the Existing Policy(ies), revoking any prior beneficiary designations.

   If a proposed life insured dies prior to the final approval of the undersigned's application for the New Policy, this Absolute Assignment / Beneficiary Change is void and of no effect.
2. The undersigned warrants that each Existing Policy is free and clear of any liens or prior assignments and is not subject to any bankruptcy or collection proceedings.
3. The undersigned understands and agrees that:
   a) Coverage under the New Policy shall not become effective until the later of the date the first premium has been paid in full and the date the New Policy has been delivered, provided that there has been no change in insurability and nothing has occurred that would require a change to any statement or answer in any part of the application, including any supplemental forms ("Undisclosed Changes"), and subject to all of the other terms and conditions of the New Policy.
   b) It is vital to inform The Company of any Undisclosed Changes as soon as possible. If an Undisclosed Change occurs prior to the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer, The Company's only obligation will be to return any funds received in connection with the application for the New Policy, and The Company will have no further obligations hereunder. If an Undisclosed Change occurs prior to the effective date of coverage of the New Policy but after the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer, The Company may reduce the face amount of the New Policy to the amount of coverage under the Existing Policy(ies), if less than the amount applied for under the New Policy.
   c) Provided that no Undisclosed Changes occurred prior to the transmittal of this form to the Existing Insurer, if the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer, The Company will pay a death benefit to the beneficiary named in the application for the New Policy equal to the lesser of (i) the amount of insurance applied for under the New Policy, or (ii) the total amount of death proceeds that would have been payable under the above referenced Existing Policy(ies), subject to all of the terms and conditions of the Existing Policy(ies). If the Existing Insurer rescinds any of the above referenced Existing Policy(ies) or otherwise dishonors this Absolute Assignment / Beneficiary Change or The Company's surrender request with respect to any Existing Policy(ies), the amount of death proceeds that would have been payable under such Existing Policy(ies) will not be included in the calculation of the total amount of death proceeds set forth in (ii) above.

EXCHANGES TO NEW POLICY continued

3. d) If the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer, any amounts paid by the Existing Insurer under the Existing Policy(ies) to a claimant other than The Company shall be deducted from the amount owed to the beneficiary named in the application for the New Policy under the provisions set forth in paragraph c) above.
4. The undersigned is responsible for and agrees to pay any and all premium payments that may come due prior to The Company's acceptance of the Absolute Assignment / Beneficiary Change, as confirmed by its signature below, in accordance with the terms of such Existing Policy(ies).
5. The undersigned agrees that notwithstanding this Absolute Assignment / Beneficiary Change, the Existing Insurer shall be responsible for: 1) the failure to properly calculate the values of the Existing Policy(ies); 2) the delay or failure in paying surrender values to The Company; and 3) the failure or delay in providing to The Company the accurate cost basis, Modified Endowment Contract ("MEC") status, and income tax gain information on the Existing Policy(ies). The Company shall have no obligation or liability relating to or arising from these responsibilities.
6. The undersigned understands and agrees that at any time prior to the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer requesting the surrender of the Existing Policy(ies) for the cash surrender value, The Company may release this Absolute Assignment / Beneficiary Change and reassign ownership of the Existing Policy(ies) to the undersigned.
7. If the undersigned should subsequently decide to cancel the application for the New Policy or return the New Policy under the "free look" provision, The Company will release this Absolute Assignment / Beneficiary Change. It is understood that in the event of the cancellation of the application or return of the New Policy under the "free look" provision, the undersigned may not be able to return the cash surrender proceeds to the Existing Insurer and/or reinstate the Existing Policy(ies) as most insurance policy contracts do not extend the right of reinstatement if a policy was surrendered. If The Company has already requested the surrender of any Existing Policy(ies), The Company's only obligation hereunder shall be the return of all premiums received. Such refund of premiums shall be paid, at the direction of the undersigned, either to the undersigned or to the Existing Insurer.
8. The Company is furnishing this form and is participating in this transaction at the undersigned's specific request, as an accommodation to the undersigned. The undersigned states and agrees that The Company makes no representations concerning the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise, and The Company has no responsibility or liability for the validity of this Absolute Assignment / Beneficiary Change nor the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise.
9. The undersigned understands that any outstanding loan(s) on any Existing Policy(ies) at the time of the assignment that is not transferred and applied to the New Policy may be reported to the Internal Revenue Service by the Existing Insurer as a distribution and will be taxable up to the amount of gain in such Existing Policy(ies) immediately prior to the assignment.

SIGNATURES

Signed at City State This Day of Year

Signature of Agent/Registered Representative as Witness

X

Signature of Owner (if corporation, officer(s) and title(s) must be indicated)

X

Signature of Owner (if corporation, officer(s) and title(s) must be indicated)

X

CONFIRMATION - FOR INTERNAL USE ONLY

Accepted by: John Hancock Life Insurance Company (U.S.A.)

This Day of Year Signature of Company Official

X