Instructions for Application For Individual Life Insurance

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

This kit is for all John Hancock new business, excluding John Hancock New York

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

1. Do You Have the Correct Form?

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

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

For more details, see our **State of Issue Guidelines** flyer.

2. Survivorship Coverage

Ensure you complete and submit the **Survivorship Supplement for Second Life (ICC19 NB6001 or NB5211)**.

3. Business Coverage

Ensure you complete and submit the **Financial Supplement for Business Insurance (ICC19 NB6014 or NB5124)**.

4. Request for Taxpayer Identification Number and Certification

The **Request for Taxpayer Identification Number and Certification, NB3072** must be completed and submitted with the application.

5. Buyer's Guide

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

6. Replacements

Ensure you are compliant with the replacement regulations for your state. For additional information refer to **Tips From Your Replacements Team**.

7. Special Rider Instructions

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

Healthy Engagement (Vitality PLUS) Rider

An **Insured email address is required** when the Healthy Engagement (Vitality PLUS) Rider is elected. This email will be used to provide detailed instructions to the insured on how to register for the John Hancock Vitality PLUS Program, and important information about how to access discounts and rewards.

John Hancock will not sell email addresses or send solicitations, and clients can limit or opt out of communications.

Long-Term Care Rider

Complete and submit the **Application Supplement, NB5018**.

Complete and submit the **Third-Party Ownership Disclosure Long-Term Care Riders, NB5193US**, if the policy will be owned by a third party.

Complete and submit the **Notice of Replacement, NB5019**, if other coverage will be replaced.

Provide the Proposed Insured with:

- **Notice of Protected Health Information Privacy Practices, NB5059US**.
- **Shopper's Guide to Long-Term Care Insurance, LTC-1059.** This guide is available on a link to the 'View My Forms' Page when searching for a kit using 'New Business Online Forms'.
- **Guide to Health Insurance for People with Medicare, LTC-1014**, if the Proposed Insured is age 65 or older. This guide is available on a link on the 'View My Forms' Page when searching for a kit using 'New Business Online Forms'.
- **Outline of Coverage, 18OCLTCR, 14OCLTCR or 05OCLTCR**.

Critical Illness Benefit Rider

Complete and submit the **Application Supplement, NB5230.**

Complete and submit the **Third-Party Ownership Disclosure Long-Term Care Riders, NB5240,** if the policy will be owned by a third party.

Critical Illness Benefit Rider (continued)

Complete and submit the **Notice of Replacement, NB5232,** if other coverage will be replaced.

Provide the Proposed Insured with the **Outline of Coverage, 17OCCIBR.**

Accelerated Benefit Rider (for terminal illness) - Provide the **Owner** with the **Summary and Disclosure Statement for Accelerated Benefit, NB1237**.

8. LifeTrack – Please Note to Avoid Delays at Policy Issue

For all products that have the LifeTrack option available, JH Illustrator will default to selecting this tool when you run an illustration. In addition, it will automatically print the LifeTrack Election Form that must be signed by the client and submitted prior to policy issue.

If your client does NOT want to take advantage of LifeTrack, deselect it on JH Illustrator. Otherwise, New Business will ask for the completed LifeTrack Election Form at policy issue.

9. Employer/Corporate Owned Policies

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

10. Military Personnel Policies

Military Personnel policies are policies where an active duty service member is the Proposed Insured or the Owner of a policy on the life of their spouse or children. For these applications, **Military Personnel Financial Services Disclosure Regarding Insurance Products, NB5109** must be submitted. This form is available in the Non Underwriting Forms section of 'View My Forms'.

11. Coverage Details

If you are applying for more than one policy with the same insured, owner and beneficiary, you may complete a stand-alone Coverage Details instead of completing an additional application. Please remember to refer to your illustration for up-to-date states approvals, and to ensure you are selecting the correct product, benefits and riders on the application. You can use the chart below as a guide to which riders and benefits are available on Flexible Premium Products.

Term Insurance	
Riders and Benefits	**Available on**
Total Disability Waiver Rider	All Term products excluding One-Year Term
Accelerated Benefit Rider	All Term products excluding One-Year Term
Unemployment Protection Rider	All Term products excluding One-Year Term
Healthy Engagement (Vitality PLUS) Rider	John Hancock Term

Universal Life	
Riders and Benefits	**Available on**
Accelerated Benefit Rider	All UL single life products
Cash Value Enhancement Rider	All UL products, excluding Protection UL, Protection SUL, UL-G & SUL-G
Disability Payment of Specified Premium	All UL products
Estate Preservation Rider (Four Year Term)	Survivorship UL products
Healthy Engagement (Vitality PLUS) Rider	Protection UL, Protection IUL, Accumulation IUL & Protection SIUL
Long-Term Care Rider	All UL single life products
Critical Illness Benefit Rider	All UL single life products
Overloan Protection Rider	Accumulation IUL
Policy Split Option	Survivorship UL products
Return of Premium Rider	All UL products excluding UL-G & SUL-G
Preliminary Funding Account	Accumulation IUL

Variable Life	
Riders and Benefits	**Available on**
Accelerated Benefit Rider	Protection VUL, Accumulation VUL
Cash Value Enhancement Rider	All Variable Life products
Disability Payment of Specified Premium	Protection VUL & Accumulation VUL
Estate Preservation Rider (Four Year Term)	Survivorship VUL products
Healthy Engagement (Vitality PLUS) Rider	Accumulation VUL & Protection VUL
Long-Term Care Rider	Protection VUL & Accumulation VUL
Critical Illness Benefit Rider	Protection VUL & Accumulation VUL
Overloan Protection Rider	All Variable Life products
Policy Split Option	Survivorship VUL products
Return of Premium Rider	Accumulation VUL & SVUL

John Hancock

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Application For Individual Life Insurance

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

If applying for Survivorship Coverage, please also complete *Survivorship Supplement for Second Life ICC19 NB6001.*
Print and use black ink. Any changes must be initialed by the Proposed Insured and the Policy Owner.

IMPORTANT NOTICE: Your application is a critical source of information for consideration of your request for insurance coverage. Therefore:

- We strongly urge you to be complete and accurate in your responses so that we may provide you with the best coverage we can.
- If we determine that your answers on this application are incorrect, incomplete, or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage.

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Sex ☐ Male ☐ Female

3. Date of Birth MONTH DAY YEAR

4. Place of Birth STATE/COUNTRY

5. Social Security Number

6. Driver's License Number/State

7. Citizenship
☐ US ☐ Non US - Country of Citizenship _____
Type of Green Card/VISA _____

8. Primary Residence STREET ADDRESS CITY STATE ZIP CODE

9. Telephone Numbers
PERSONAL BUSINESS

10. Email Address ! *Your email is required so we may communicate with you about your policy online*

11. Occupation
☐ Job/Duties _____ Employed by _____
☐ Student ☐ Homemaker ☐ Unemployed ☐ Retired ☐ Other _____

12. Are you currently a member of the armed forces, including the reserves?
☐ Yes ☐ No ! *If Yes, complete Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109*

13. Gross Annual Household Income
Salary $ _____ Other $ _____

14. Household Net Worth
$ _____

15. In the last 5 years, has the Proposed Insured or any business of which he/she is a partner/owner/executive been bankrupt, had any liens, or judgements?
☐ Yes ☐ No - *If Yes, provide details* _____

SECTION B: Policy Owner

- Complete if Policy Owner is someone other than the Proposed Insured
- List additional Policy Owners and details in *SECTION K: ADDITIONAL INFORMATION*

16. a. Policy Owner Type

☐ Individual ☐ Business ☐ Existing Trust ☐ Trust to be Established

If Trust Owner, complete the Trust Certification PS5101

If Partnership Owner, complete the Partnership Statement PS7800US

☐ Other _____

b. Policy Owner Relationship

☐ Spouse ☐ Child ☐ Trust

☐ Business Partner ☐ Employer

☐ Other _____

c. Name or Entity/Trust Name FIRST MIDDLE LAST

d. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Address STREET ADDRESS CITY STATE ZIP CODE

g. Telephone Number

h. Email Address *Your email is required so we may communicate with you about your policy online*

17. Multiple Policy Owners - Type of Ownership ☐ Joint with right of survivorship ☐ Tenants in common

18. Is the Policy Owner a Non US Person or a Non Resident Alien?

☐ Yes ☐ No *If Yes, Complete IRS Form W-8BEN for individuals*

SECTION C: Beneficiary Information

- This section is to be completed by Policy Owner
- Beneficiary listed in question 19 is always assigned as Primary
- List additional beneficiaries in *SECTION K: ADDITIONAL INFORMATION*

19. a. Name or Entity/Trust Name FIRST MIDDLE LAST

b. Percentage _____ %

c. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner

☐ Employer ☐ Other _____

d. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Telephone Number

g. Email Address

h. Address STREET ADDRESS CITY STATE ZIP CODE

20. a. Name or Entity/Trust Name FIRST MIDDLE LAST

b. Percentage _____ %

c.

☐ Primary

☐ Secondary

d. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner

☐ Employer ☐ Other _____

e. Date of Birth or Trust Date (if applicable)

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

f. Social Security OR Tax ID

☐ SSN

☐ Tax ID

g. Telephone Number

h. Email Address

i. Address STREET ADDRESS CITY STATE ZIP CODE

SECTION D: Coverage Details

- This section is to be completed by Policy Owner
- Refer to your illustration for riders and benefits selected

21. Product Name *(see Policy Illustration Summary Page)* _____

22. Flexible Premium Products

☐ Universal Life ❗ *If applying for Indexed UL, complete Premium Allocation Instructions ICC19 NB6017*

☐ Variable Universal Life ❗ *Complete Fund Allocation ICC19 NB6016*

a. ☐ Single Life

☐ Survivorship ❗ *Complete Survivorship Supplement for Second Life ICC19 NB6001*

b. ☐ Base Face Amount $ _____

☐ Supplemental Face Amount $ _____ (not available with all products)

☐ Level ☐ Increasing by _____ % for _____ Years

☐ Customized Increasing Schedule ❗ *Complete Customized Schedule NB5064*

c. Death Benefit Option ☐ Option 1 (Death Benefit = Face Amount) ☐ Option 2 (Death Benefit = Face Amount + Policy Value)

d. Life Insurance Qualification Test ☐ Guideline Premium Test (GPT) ☐ Cash Value Accumulation (CVAT)

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

☐ Accelerated Death Benefit (for terminal illness) ❗ *Complete Summary and Disclosure Statement for Accelerated Benefit NB1237*

☐ Long-Term Care Rider ❗ *Complete Application Supplement (Long-Term Care Rider) ICC13 NB5018*

☐ Critical Illness Benefit Rider ❗ *Complete Application Supplement: Individual Insurance Critical Illness Benefit Rider NB5230*

☐ Cash Value Enhancement Rider

☐ Healthy Engagement (Vitality PLUS) Rider

☐ Disability Payment of Specified Premium Rider
Monthly Specified Amount $ _____

☐ Estate Preservation Rider

☐ Overloan Protection Rider

☐ Policy Split Option Rider

☐ Return of Premium Rider *(Death Benefit Option 1 only)*
Percentage of premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %

☐ Preliminary Funding Account

☐ Other _____

☐ John Hancock Aspire – a solution for people living with diabetes *(not available in ID)*

23. Term Products *(choose at least one product and duration)*

☐ Protection Term: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ 30 Years ☐ Other _____

OR

☐ Vitality Term: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ 30 Years ☐ Other _____

❗ *This product automatically includes the Vitality PLUS Program, which provides premium savings and rewards for the everyday things you do to stay healthy. Your premiums may decrease, stay level, or increase based on insured's participation in the program. The Vitality PLUS Program cannot be dropped at a later date, as it is a built-in feature of this product.*

a. Face Amount $ _____

b. Riders and Benefits (if applicable)

☐ Total Disability Waiver

☐ Accelerated Death Benefit (for terminal illness)

❗ *Complete Summary and Disclosure Statement for Accelerated Benefit NB1237*

☐ Unemployment Protection Rider

☐ Healthy Engagement (Vitality PLUS) Rider (Protection Term only)

❗ *When you select this rider, the Vitality PLUS Program will be included with your Protection Term Life insurance policy. Your premiums may stay level or decrease (but never increase) based on insured's participation in the program. The Healthy Engagement Rider can be dropped at any time. The rider is not available on the Vitality Term product.*

☐ Other _____

☐ John Hancock Aspire – a solution for people living with diabetes *(not available in ID)*

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

Plan Name _____ Face Amount $ _____

SECTION E: Purpose and Funding Information

- This section is to be completed by Policy Owner
- List additional information in *SECTION K: ADDITIONAL INFORMATION*
- All Premium Notices and Correspondence are sent to the Policy Owner at the address provided in Section B

25. a. Billing Method

☐ Pre-Authorized Payment Plan ❗ *Complete Request for Pre-Authorized Payment Plan NB5087*

☐ Direct Bill (not available for monthly billing)

b. Please select billing frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Pre-Authorized Payment Plan only)

26. Existing Life Insurance

a. Does the Policy Owner have any existing life insurance and/or annuities with this or any other company?

☐ Yes ❗ *If Yes, refer to the Instructions for Application for Individual Life Insurance regarding additional required Replacement forms*

☐ No

b. Will this insurance replace any existing life insurance policies and/or annuities, or are you, the Policy Owner, considering using funds from existing policies or annuities to pay premiums on the new policy?

☐ Yes ❗ *If Yes, refer to the Instructions for Application for Individual Life Insurance regarding additional required Replacement forms*

☐ No

27. Purpose of Insurance

☐ Income Replacement ☐ Estate Planning

☐ Business Insurance ❗ *Complete Financial Supplement for Business Insurance ICC20 NB6014*

☐ Other - give details _____

28. Lapse Notification Handling

Secondary Addressee: In addition to the Policy Owner, The Company will mail lapse notices for overdue premiums to any Secondary Addressee you designate. If you want this option, provide the following information for the Secondary Addressee:

a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

c. Address STREET ADDRESS CITY STATE ZIP CODE

29. a. Other than the Policy Owner, Proposed Insured(s) and beneficiaries specified herein, does or will any person or entity have any right, title or interest in any policy issued as a result of this application?

☐ Yes ☐ No - If Yes, give details _____

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

☐ Yes ☐ No - If Yes, give details _____

30. Premium (Payment) Source

☐ Income

☐ Liquidated Assets - give details _____

☐ Proceeds from Sold or Viaticated policy - give details _____

☐ Loan ❗ *If you checked Loan, complete Question 31 a, b, and c on next page*

☐ Other - give details _____

SECTION E: Purpose And Funding Information *continues on next page*

SECTION E: Purpose And Funding Information (continued)

Only complete question 31, a, b and c if 'Loan' was selected in question 30

31. a. Name all lenders involved

b. What amount and type of collateral is required to secure the loan and/or loans?

Amount $ _____ Type of collateral _____

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

☐ Yes ☐ No - If Yes, give details _____

SECTION F: Existing, Replacement, And Pending Insurance Information

- This section is to be completed by Proposed Insured
- List additional policies in *SECTION K: ADDITIONAL INFORMATION*

32. a. Is the Proposed Insured under this application also an insured on any other existing life insurance policy, including any policy that has been sold, assigned, transferred or settled?

☐ Yes ☐ No ❗ *If you checked Yes, complete Question 32b*

b. If Yes, provide details for each existing Life Insurance policy on the Proposed Insured with all companies

INSURANCE COMPANY	INSURANCE PURPOSE		YEAR ISSUED	SURVIVORSHIP		TO BE REPLACED		1035 EXCHANGE		SOLD, ASSIGNED TRANSFERRED OR SETTLED		FACE AMOUNT INCLUDING RIDERS
	PERSONAL	BUSINESS		YES	NO	YES	NO	YES	NO	YES	YEAR	
	☐	☐		☐	☐	☐	☐	☐	☐	☐		$
	☐	☐		☐	☐	☐	☐	☐	☐	☐		$

33. a. If life insurance coverage is being applied for on the Proposed Insured with any other company, provide the face amount of all applications and name of the life insurance company. Do not include informal inquiries.
If "None" check this box ☐

INSURANCE COMPANY	FACE AMOUNT INCLUDING RIDERS
	$
	$

b. What is the total amount of new Life Insurance coverage that you plan to accept with all companies including this application? $ _____

SECTION G: Personal Information

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

34. The information you provide in this application is critical to our consideration of your request for insurance coverage. You are strongly urged to answer all questions completely and accurately so that we may provide you with the best coverage we can. We will seek information from other sources to assist us with evaluating your application, potentially including your health care provider. If your answers are incorrect, incomplete or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage. Please know that your personal information, including health information, is protected by The Company and only used by The Company to do business with you, and as permitted or required by law.

X ____ Initial here to acknowledge that you have carefully reviewed and fully understand the above statement.

35. a. Primary Physician Name FIRST LAST ☐ Check if Proposed Insured does not have a physician

b. Address STREET ADDRESS CITY STATE ZIP CODE c. Telephone Number

d. Date of last visit MONTH DAY YEAR

e. Reason for last visit, outcome and treatment prescribed

36. a. Name of Medical Group/Health Care Provider (if applicable)

b. Name of Health Insurance Provider (if applicable)

37. Provide name, address, and phone number of any other specialists or member of the medical profession consulted in the past 24 months.

• *If you need more space, continue listing in SECTION K: ADDITIONAL INFORMATION.*

38. Describe your complete tobacco/nicotine products usage history, including but not limited to: cigarettes, e-cigarettes, cigars, pipe, chewing tobacco, snuff, hookah, nicotine patch, nicotine gum.
NOTE: Tobacco use does not automatically nor necessarily result in denial of coverage.

• *If products used exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF PRODUCT	QUANTITY AND UNIT (Ex. Packs, cigarettes, patches, etc.)	FREQUENCY	DATE LAST USED (MONTH/YEAR)
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	

☐ I have never used nicotine/tobacco products

SECTION G: Personal Information *continues on next page*

SECTION G: Personal Information (continued)

39. Describe your marijuana use in the past 5 years.

NOTE: Marijuana use does not automatically nor necessarily result in denial of coverage

PURPOSE

☐ Recreational/Social

☐ Medicinal – Provide Prescription Card ID _____

Date Last Used

MONTH YEAR

FREQUENCY

_____ times per ☐ Day ☐ Month ☐ Year

DELIVERY METHOD

☐ Ingested ☐ Vaporized ☐ Inhaled

☐ I have not used marijuana in the past 5 years

SECTION H: Lifestyle Information

• This section is to be completed by Proposed Insured as it pertains to his or her own lifestyle history

40. Describe your exercise routine, such as walking, running, treadmill, swimming, aerobics, strength training, cycling, sports or yoga.

• *If exercises exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF EXERCISE	FREQUENCY	TIME SPENT PER SESSION
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes

☐ I do not participate in an exercise routine

41. Have you ever had an application for life insurance declined, postponed, rated substandard, modified, requiring extra premium, or offered less than applied for by any company?

☐ Yes ☐ No

If Yes, give details of decision type, reason and date _____

42. In the past 12 months, have you missed more than 10 consecutive days of work, school, or your daily/regular activities because of illness, injury, or medical treatment?

☐ Yes ☐ No

If Yes, provide details _____

SECTION H: Lifestyle Information *continues on next page*

SECTION H: Lifestyle Information (continued)

43. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?

☐ Yes ☐ No

If Yes, give details of location (city/country), purpose, frequency and duration _____

44. Have you ever flown or intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes?

☐ Yes ☐ No ❗ *If Yes, complete Aviation Questionnaire ICC16 NB6009*

45. Please indicate any of the following activities you participate in or have participated in, within the last 2 years:

☐ Motorcycle racing ☐ Scuba diving ☐ Power boat racing ☐ Skydiving/Parachuting
☐ Mountain climbing ☐ Ballooning ☐ Hang-gliding ☐ Backcountry skiing/snowmobiling
☐ Bungee/base jumping ☐ Heli skiing ☐ Motor vehicle racing ☐ I do not participate in any of these activities

❗ *If any activities selected, complete Avocation Questionnaire ICC16 NB6010*

46. Please indicate which of the following apply to your driving history:

☐ Convicted of 1 or more moving violations in the past 2 years ☐ Convicted of driving while intoxicated or otherwise impaired
☐ License is currently revoked or suspended ☐ None of these apply to me

47. Have you ever been convicted of, plead guilty for, or are you currently awaiting trial for any infraction, misdemeanor or felony?

☐ Yes ☐ No

If Yes, give details of type, date, city/state of felony and/or crime and if currently on probation or parole

_____

_____

SECTION I: Juvenile Insurance

• Complete only if Proposed Insured is under age 18

48. a. Are all siblings equally insured?

☐ Yes ☐ No

If No, give details _____

_____

b. Amount of life insurance currently in force or pending for:

Mother $ _____ If none, provide reason: _____

Father $ _____ If none, provide reason: _____

Guardian $ _____ If none, provide reason: _____

SECTION J: Temporary Life Insurance Agreement Application

- You may be eligible for Temporary Life Insurance Coverage. Please speak with your Agent/Representative for details on the amount and benefit period. This section is to be completed only if you are applying for Temporary Life Insurance.

Instructions for Agent/Representative

- Money may only be collected with this application and the Temporary Life Insurance Receipt and Agreement ICC16 NB6004 may only be issued if:
  1. questions 49, 50 and 51 are answered "No"
  2. the Proposed Insured is age 20 to 70
  3. the amount applied for under this application is not greater than $10,000,000 (single life) or $15,000,000 (survivorship)

  Note: Temporary Life Insurance questions must be answered by both insureds if Survivorship coverage is being applied for. See *Survivorship Supplement for Second Life ICC19 NB6001*.

	PROPOSED INSURED
49. Within the last 24 months, has the Proposed Insured under this application:	
a. consulted a member of the medical profession for, been diagnosed with or been treated for any heart problem, stroke or cancer?	☐ Yes ☐ No
b. received a recommendation (excluding HIV) from a member of the medical profession for any consultation, testing, investigation or surgery that has not yet been completed?	☐ Yes ☐ No
c. been declined for life insurance?	☐ Yes ☐ No
50. Other than planned routine check-ups, in the last 24 months have there been any pending medical tests or follow-up for medical concerns or symptoms (excluding HIV) for which a medical professional should be consulted?	☐ Yes ☐ No
51. Does the Proposed Insured reside outside the United States more than 6 months per year?	☐ Yes ☐ No

SECTION K: Additional Information

- This is an additional section if more space is required for any of the previous sections, e.g. listing additional beneficiaries from SECTION C, listing additional policies from SECTION F, listing additional tobacco products from SECTION G, etc.

SECTION	QUESTION NUMBER	DETAILS

SECTION L: Special Instructions

Read the following carefully and sign next page

DECLARATIONS

The Proposed Insured (or Parent or Guardian) and Policy Owner 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. All such statements and answers are representations, not warranties.

In addition, I/we 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 Insured, will become part of the insurance policy issued as a result of this application. No information about me will be considered to have been given to The Company unless it is stated in the application or any form that is made part hereof.
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 Policy Owner, provided that the Proposed Insured is still living and nothing 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 as of the date this policy becomes effective. If there has been such an occurrence: (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.
   - **c)** Only an officer of The Company may make, modify, or discharge any insurance contract on its behalf. No agent has the authority to: (i) accept risks; (ii) determine insurability; (iii) make or modify any contractual provision; or (iv) waive any of The Company's rights or requirements.
3. **Employer Owned Policies:** The Proposed Insured confirms that they have received, prior to issue, written notice that indicates: (i) the employer's intent to insure the Proposed Insured, (ii) the maximum amount of the insurance to be issued on the life of the Proposed Insured and (iii) that the employer will be the beneficiary of the new policy. The Proposed Insured 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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
5. **Variable Policies: I/We acknowledge that the policy values that are based on the separate account assets are not guaranteed and will decrease or increase with investment experience.** 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 ICC16 NB6004.
8. **Healthy Engagement Benefit:** If a policy is issued with the Healthy Engagement rider or benefit (the Benefit), the Proposed Insured will receive a membership in a healthy engagement program offered by a third party program provider. By applying for the Benefit, the Proposed Insured authorizes The Company to share his/her personal information, including certain health information, with the provider in connection with the registration for the program and administration of the Benefit. The Proposed Insured understands and agrees that (i) his/her program membership will be subject to the provider's privacy policy and terms and conditions of membership, which the Proposed Insured should read prior to joining the program, and (ii) he/she will be asked to authorize the provider to share his/her health, lifestyle, medical or other personal information with The Company. The Proposed Insured will not be eligible to participate in the program if the terms and conditions of membership are not accepted. Upon termination of the policy or rider, as applicable, the program membership will terminate and access to further benefits and incentives, if any, will cease as provided in the terms and conditions. The Company is not responsible or liable for any damage, loss or injury arising out of the Proposed Insured's participation in any third party healthy engagement programs or receipt of any products or services provided through such programs.

Read carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me.

2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, the MIB, Inc. ("MIB") or any other similar person or organization to disclose health information about me or any minor child who is to be insured. Health information includes: (i) my entire medical record and medical history, prescription history, and other health information; (ii) confidential information related to Human Immunodeficiency Virus (HIV), other communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to disclose financial/net worth information about me.

Such disclosure of my information may be made to The Company, its affiliated companies, agents, service providers, reinsurers, MIB or any person or entity entitled to receive such information by law or as I may further consent.

Information collected under this authorization will be used to evaluate my application for insurance, identify any misrepresentation in the information provided by me in this application, administer coverage, evaluate a claim for benefits, for reinsurance or other insurance purposes, or to conduct other legally permissible activities. I authorize The Company, or its reinsurers, to make a brief report of my health information to MIB.

This authorization is valid for 24 months from the date shown below or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter. A photocopy of this authorization will be as valid as the original. I am entitled, or my authorized representative is entitled, to a copy of this authorization.

I understand that I can revoke this permission to collect information at any time by providing written notification to John Hancock Life Insurance Company (U.S.A.) at the Service Office address (page 1) Attention: Chief Underwriter, but any revocation will not affect such information that has already been collected and relied on by The Company.

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

SIGNATURES – *If Proposed Insured is under age 15, Parent or Guardian must sign on the Proposed Insured Signature Line and include relationship*

X _____

SIGNATURE OF POLICY OWNER (PROVIDE TITLE OR CORPORATE SEAL, IF SIGNING OFFICER)

_____

POLICY OWNER - SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF PROPOSED INSURED IF OTHER THAN POLICY OWNER (PARENT OR GUARDIAN IF UNDER AGE 15)

AGENT SIGNATURE

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

X _____ _____

SIGNATURE OF AGENT/REPRESENTATIVE DATE

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Request For Taxpayer Identification Number and Certification

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

(hereinafter referred to as The Company)

Please Read Instructions before Completing Form

- This form must be completed by each Owner who is a U.S. person, including a U.S. citizen, U.S. resident alien or other U.S. person. You may submit a completed IRS Form W-9 instead of this form. Please see the IRS instructions to Form W-9 for more information, including the definition of a U.S. person.
- If you are not a U.S. person, do NOT complete this form. Instead, please complete the appropriate Form W-8.
- Forms W-9, W-8 and their instructions are available at the IRS website **http:/www.irs.gov/Forms-&-Pubs**

OWNER/LIFE INSURED INFORMATION

1. a) Name of Life Insured(s)	b) Policy Number
c) Owner Name (as shown on your income tax return)	d) Telephone No. of Owner
e) Business Name/disregarded entity name, if different from above	
f) Owner Address Street Address / City / State / Zip Code	

FEDERAL TAX CLASSIFICATION

Please check appropriate box to indicate how you are taxed for federal income tax purposes:

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate

☐ Limited Liability Company: Check the tax classification ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Other _____

Exemptions (see instructions on page 2)

☐ Exempt Payee Code (if any) _____

☐ Exemption from FATCA reporting code (if any) _____

TAXPAYER IDENTIFICATION NUMBER (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). For other entities, it is your employer identification number (EIN). If you have applied for a number and are waiting for one to be issued, please check the Applied For box below. You then have 60 days to submit a certified TIN in order to avoid backup withholding.

Social security number _____ Employer identification number _____ ☐ Applied For

CERTIFICATION

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because:
   a. I am exempt from backup withholding, or
   b. I have not been notified by the Internal Revenue Services (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
   c. The IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (as defined in the instructions to Form W-9), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification Instructions

You must check the box below if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends.

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

Please note that by signing this form, you declare that you make the above certifications under penalties of perjury.

SIGNATURE

Under penalties of perjury, I certify the above statements.

X _____ _____

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

INSTRUCTION FOR EXEMPTION CODES

Some taxpayers are exempt from backup withholding and/or FATCA reporting. If you are exempt, please enter your exemption code(s) in the appropriate field in the Federal Tax Classification section. The codes are identified below. Sections cited below are from the Internal Revenue Code.

Exempt Payee Code

Taxpayers who are exempt from backup withholding should enter the applicable code from the following list. Generally, individuals, including sole proprietors, and personal trusts are **not** exempt from backup withholding.

1. An organization exempt from tax under section 501(a).
2. The United States or any of its agencies or instrumentalities.
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities.
5. A corporation
6. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States.
7. A futures commission merchant registered with the Commodity Futures Trading Commission.
8. A real estate investment trust.
9. An entity registered at all times during the tax year under the Investment Company Act of 1940.
10. A common trust fund operated by a bank under section 584(a)
11. A financial institution
12. A middleman know in the investment community as a nominee or custodian.
13. A trust exempt from tax under section 664 or described in section 4947.

Exemption from FATCA reporting code

The following codes identify payees exempt from reporting under the Foreign Account Tax Compliance Act. These codes apply to persons submitting this form for accounts maintained outside the U.S. by certain foreign financial institutions. **If you are submitting this form for an account you will hold in the United States, you may leave this field blank.**

A. An organization exempt from tax under section 501(a).

B. The United States or any of its agencies or instrumentalities

C. A state, the District of Columbia, a possession of the U.S., or any of their political subdivisions or instrumentalities.

D. A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i).

E. A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i).

F. A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options),registered as such under the laws of the U. S. or any state.

G. A real estate investment trust.

H. A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I. A common trust fund as defined in section 584(a).

J. A bank as defined in section 581.

K. A broker.

L. A trust exempt from tax under section 664 or 4947(a)(1).

M. A tax exempt trust under a section 457(g) plan.

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

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 the Application for Individual Life Insurance.

SECTION A: Proposed Insured(s)

LIFE ONE

1. Name FIRST MIDDLE LAST

LIFE TWO

2. Name FIRST MIDDLE LAST

SECTION B: General Information

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

4. a. Does or will any person or entity (other than the Owner, Proposed Insured(s) and beneficiaries specified in the application) have any right, title or interest in any policy issued as a result of the application? For example, an arrangement where the Owner has or will have an option to sell an interest in the policy to a third party. ☐ Yes ☐ No If Yes, give details:

   b. Will any policy issued 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 Insured or the Proposed Insured's employer? ☐ Yes ☐ No

5. Will any entity other than a life insurance company be medically evaluating the Proposed 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 Insured(s)? ☐ Yes ☐ No If No, answer question 6 b.

   b. Describe how the application was solicited and completed.

SECTION C: Employer Owned Policies

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

   b. The Proposed 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 Insured(s) that the employer will be the beneficiary of the policy. ☐ Yes ☐ No

   c. The Proposed Insured(s) has provided written consent to being insured and that such coverage may continue after the employment relationship terminates. ☐ Yes ☐ No

SECTION D: Existing and Replacing Insurance

8. a. Does the Policy Owner have any existing life insurance and/or annuities with this or any other company? ☐ Yes ☐ No

   b. Will this insurance replace any existing life insurance policies and/or annuities, or is the Policy Owner considering using funds from existing policies or annuities to pay premiums on the new policy? ☐ Yes ☐ No
   - *If Yes to either (a) or (b), refer to the Instructions for Application for Individual Life Insurance regarding additional required Replacement forms.*
   - If Accident and Sickness - Critical Illness or Long-Term Care is being replaced, please give the Proposed Insured the applicable form(s):
     - **IMPORTANT NOTICE: Replacement of Accident and Sickness Insurance – Critical Illness Benefit Rider NB5232.**
     - **IMPORTANT NOTICE: Replacement of Long-Term Care Insurance NB5019.**

   c. List any other health insurance policies you have sold to the applicant

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

SECTION E: Agent Information

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			BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS	
100 %	☐ Yes				

b.

NAME OF AGENT/ENTITY			BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS	
%	☐ Yes				

c.

NAME OF AGENT/ENTITY			BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS	
%	☐ Yes				

10. Name of Wholesaler (if applicable) _____

SECTION F: Certification and Signature

• An Agent/Registered Representative for this policy must sign this form

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

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Indexed UL – Premium and Segment Proceeds Allocation Instructions

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

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

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: Owner(s) – Complete information only if Owner(s) is other than Proposed Insured.

3. Name of Owner(s)

SECTION C: Premium Payment Allocation – The section must be completed for all Indexed Universal Life policies. Allocation must be in whole numbers. Please refer to your illustration for account availability and associated fees.

If you wish to elect Automated Transfers from the Fixed Account* to the Indexed Account(s) by completing Section D of this form below, you must allocate a percentage of your premium payments to the Fixed Account.

4. Allocate premium payment to the following accounts. The initial premium allocation elections on the issue illustration must match the elections in question 4 or the elections in the "to" field of question 5 (if applicable).

_____ % Fixed Account
_____ % Base Capped Indexed Account [1.]
_____ % Base High Par Capped Indexed Account
_____ % Select Capped Indexed Account [2.]
_____ % Capped Indexed Account
_____ % High Capped Indexed Account
_____ % High Par Capped Indexed Account
_____ % Capped Hang Seng Indexed Account
_____ % Enhanced Capped Indexed Account [3.]
_____ % Enhanced High Capped Indexed Account [3.]
0.00 % **Total (must equal 100%)**

Your premium allocation instructions will remain in effect for all future payments, until such time that you submit new premium allocation instructions.

* We refer to the Fixed Account as the Guaranteed Interest Account in your policy.
1. NOT available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
2. ONLY available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
3. ONLY available on Accumulation IUL and Majestic Accumulation IUL.

SECTION D: Automated (Recurring) Transfers from Fixed Account to Indexed Account(s) (Optional)

5. On a monthly basis, you may authorize transfers from the Fixed Account to the Indexed Account(s) by completing the section below. Select a dollar amount of the Fixed Account balance that you wish to transfer each month.

Monthly Transfer Dollar Amount $ _____ Number of Transfers (Optional) _____ (minimum 2)

$ _____ Base Capped Indexed Account [1.]
$ _____ Base High Par Capped Indexed Account
$ _____ Select Capped Indexed Account [2.]
$ _____ Capped Indexed Account
$ _____ High Capped Indexed Account
$ _____ High Par Capped Indexed Account
$ _____ Capped Hang Seng Indexed Account
$ _____ Enhanced Capped Indexed Account [3.]
$ _____ Enhanced High Capped Indexed Account [3.]

1. NOT available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
2. ONLY available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
3. ONLY available on Accumulation IUL and Majestic Accumulation IUL.

Beginning on the Transfer Date and continuing each Monthly Processing Date thereafter, we will transfer the requested amounts from the Fixed Account and allocate each amount to the Indexed Account(s) per the transfer instructions. The Transfer Date is the next Monthly Processing Date following the later of the Policy Date, the Issue Date or the date the premium was received to place the policy In Force. Note that the amounts available to transfer are based on net premiums (after premium load and policy charges). The Automated Transfers election will continue until such time that a) the number of transfers, if indicated, has been fulfilled, or; b) there is no value in the Fixed Account. If the balance within your Fixed Account is less than the requested Monthly Transfer Dollar Amount at the time a transfer is scheduled, a transfer of the remaining balance of the Fixed Account will take place. If the requested Automated Transfer fails due to a $0 balance in the Fixed Account, however you desired transfers to continue, a new request must be submitted once there is sufficient value in the Fixed Account.

SECTION E: Segment Proceeds Allocation (Optional)

6. Upon segment maturity, allocate segment proceeds to the following accounts. Select the FROM account and TO account on the chart provided. In the absence of any Segment Proceeds allocation instructions, your policy's Segment Proceeds will automatically be reallocated 100% to new segments of the same Index Account.

FROM:	**PERCENTAGE TO:**										
	Fixed Account	Base Capped Indexed Account [1.]	Base High Par Capped Indexed Account	Select Capped Indexed Account [2.]	Capped Indexed Account	High Capped Indexed Account	High Par Capped Indexed Account	Capped Hang Seng Indexed Account	Enhanced Capped Indexed Account [3.]	Enhanced High Capped Indexed Account [3.]	Total (must equal 100%)
Base Capped Indexed Account [1.]	%	%	%	%	%	%	%	%	%	%	0.00 %
Base High Par Capped Indexed Account	%	%	%	%	%	%	%	%	%	%	0.00 %
Select Capped Indexed Account [2.]	%	%	%	%	%	%	%	%	%	%	0.00 %
Capped Indexed Account	%	%	%	%	%	%	%	%	%	%	0.00 %
High Capped Indexed Account	%	%	%	%	%	%	%	%	%	%	0.00 %
High Par Capped Indexed Account	%	%	%	%	%	%	%	%	%	%	0.00 %
Capped Hang Seng Indexed Account	%	%	%	%	%	%	%	%	%	%	0.00 %
Enhanced Capped Indexed Account [3.]	%	%	%	%	%	%	%	%	%	%	0.00 %
Enhanced High Capped Indexed Account [3.]	%	%	%	%	%	%	%	%	%	%	0.00 %

[1.] NOT available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
[2.] ONLY available on Accumulation IUL 20 and Majestic Accumulation IUL 20.
[3.] ONLY available on Accumulation IUL and Majestic Accumulation IUL.

SECTION F: Telephone and/or Internet Transfer/Allocation Change Authorization (Optional)

7. I/We understand and agree that:

By checking the box below and providing my/our signature(s), I/we am hereby authorizing John Hancock to act upon transfer and allocation instructions by telephone and/or Internet for the following transactions:

1) Transfer (individual or recurring) from the Fixed Account to Indexed Account(s) instructions;

2) Cancellation of Transfer instructions;

3) Premium Allocation instructions; and

4) Segment Proceeds Allocation instructions.

Telephone and Internet transfer and allocation changes are subject to the terms and conditions of the policy, and the administrative requirements of the Company. In order to confirm that the instructions received by telephone or Internet are genuine, John Hancock may employ security procedures such as requiring the disclosure of a social security number, date of birth, or tape recording of the call; as well as providing the Owner(s) with a confirmation of the transaction. Transfer and allocation change request conversations may be recorded without disclosure at the time of the call.

In the event that proper identification is not provided, John Hancock reserves the right to refuse to act on transfer or allocation change instructions. Neither John Hancock nor any person authorized by John Hancock will be responsible for any claim, loss, liability or expense in connection with a transfer or allocation change if John Hancock or such other person acted on instructions in good faith and in reliance on this authorization.

All terms of this Authorization are binding upon the agents, heirs and assignees of the Owner(s). This Telephone and/or Internet Transfer/Allocation Change Authorization will be effective until such time as (a) written revocation is received by the Company's Service Office, or (b) the Company discontinues this privilege, whichever occurs first. I/We will indemnify and hold John Hancock and its directors, officers, and employees harmless from any and all liabilities and costs, including attorney fees, which may be incurred by relying upon this authorization.

I/We authorize John Hancock to accept Transfer, Cancellation of Transfer, Premium Allocation, and Segment Proceeds Allocation instructions by telephone and/or Internet from:

☐ Owner or any Co-owner only ☐ Owner or any Co-owner, and Servicing Agent

SECTION G: Owner(s) Acknowledgements and Signature(s)

I understand that under the applied for policy:

a) Indexed Account Segments are only created on a Segment Initiation Date (the 15th of each calendar month). Amounts transferred to an Indexed Account after the Lock In Date will be included in a new Segment Balance the following month.

b) Your allocations and Automated Transfer elections will remain in effect, until such time that we receive authorized instructions to change these elections.

c) Transfers and allocation changes are subject to the conditions of the policy, and the administrative requirements of the Company.

By signing below, I certify that I agree to the selections above and confirm that I have reviewed and read the conditions above. I also certify that I have reviewed the information provided and it correctly reflects my selections.

NAME OF OWNER(S)

X SIGNATURE OF OWNER(S)

NAME OF OWNER(S)

X SIGNATURE OF OWNER(S)

SIGNED AT CITY STATE THIS DAY OF YEAR

SECTION H: Agent Signature

X SIGNATURE OF AGENT

SIGNED THIS DAY OF YEAR

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

HIPAA Compliant Authorization

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 Insured.

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Date of Birth MONTH DAY YEAR

SECTION B: Authorization

This authorization is intended to comply with HIPAA. HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

I authorize the following people or entities to disclose my Protected Health Information (as defined below): any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; electronic health record provider; medical facility; other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years; any insurance company (including The Company or its affiliates) or agent from which I have applied for or obtained insurance; and any consumer reporting agency, such as the MIB, Inc. (MIB) and any other entity or person having Protected Health Information about me.

Such disclosure of my Protected Health Information may be to The Company, its affiliated companies, agents, service providers, reinsurers, or MIB.

"Protected Health Information" includes:

1. my entire medical record, medical history, prescription history, medications prescribed and any other health information concerning me;
2. information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases;
3. information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes; or
4. genetic information and genetic test results, to the extent permitted by law.

My Protected Health Information is to be used and disclosed under this Authorization for the following purposes with respect to any insurance coverage, including but not limited to life insurance and/or long-term care insurance, that I have or have applied for with The Company or its affiliates:

1. make underwriting, eligibility, risk rating, policy issuance and enrollment determinations;
2. obtain reinsurance;
3. administer coverage;
4. determine responsibility for, and to the extent obligated, pay claims and benefits;
5. determine whether incorrect, incomplete or misrepresented information was provided for purposes of evaluating a policy rescission or claims contest investigation, including with respect to insurance coverage not covered under HIPAA;
6. 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 a 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.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this Authorization. I authorize any of the entities or persons referred to above to release and disclose my Protected Health Information without restriction, including any Protected Health Information containing genetic information or genetic test results to the extent permitted by law.

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 claim or benefit payments. I understand that I or any authorized representative will receive a copy of this Authorization.

SECTION C: Signature

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____
SIGNATURE OF PROPOSED INSURED

X _____
PRINT NAME

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

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Notice of Disclosure of Information

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: 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 regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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. 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 in its file to other 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**.

SECTION C: 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.

SECTION D: 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 Insured with a copy.

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Temporary Life Insurance Receipt and Agreement

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.

SECTION A: Receipt

The Company acknowledges receipt of $ _____ paid in connection with the Application for Life Insurance dated MONTH DAY YEAR _____

on PROPOSED INSURED (LIFE ONE)

1. Name FIRST MIDDLE LAST _____

PROPOSED INSURED (LIFE TWO)

2. Name FIRST MIDDLE LAST _____

3. Name of Owner _____

MONTH DAY YEAR _____

X _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

SECTION B: Temporary Life Insurance Agreement

This Temporary Life Insurance Agreement is hereby entered into as follows:

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AND SENT TO THE SERVICE OFFICE ADDRESS. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK

The Company will pay a death benefit to the beneficiary named in the application if the Proposed Insured, or the Surviving Proposed Insured under a survivorship plan, dies while this Agreement is in effect, subject to the terms and conditions set out below.

1. **WHEN AGREEMENT APPLIES.** Coverage will be provided under this Agreement only if any of the following apply:
   a) all of the questions in the Temporary Life Insurance Agreement Application are answered "No"; and,
   b) any Proposed Insured is age 20 to age 70 as of the date that this Temporary Life Insurance Receipt and Agreement is signed by the Agent/Registered Representative ("the Effective Date"); and,
   c) the amount applied for under the above referenced Application for Individual Life Insurance is not greater than $10,000,000 of single life coverage or $15,000,000 of survivorship coverage.
2. **LIMITED AMOUNT OF INSURANCE.** The amount of Temporary Life Insurance coverage provided by The Company will be the lesser of:
   a) the amount of insurance applied for including supplementary benefits and accidental death benefit; or,
   b) $1,000,000 for individual coverage or $5,000,000 for survivorship coverage.

   This maximum amount of coverage applies to the total amount under this Agreement and any other Temporary Life Insurance Agreement with The Company covering the Proposed Insured. If there are two or more persons proposed for insurance, this maximum amount applies to the total coverage.
3. **ACCIDENTAL DEATH BENEFIT LIMITATION.** If the benefits applied for include an accidental death benefit, no such benefit will be paid in respect of a death caused by:
   a) voluntarily taking or absorbing of any drug, medicine, sedative or poison (except in connection with any Proposed Insured's employment) unless prescribed by a licensed doctor other than the Proposed Insured; or,
   b) travel in any aircraft other than as a passenger.
4. **DATE INSURANCE BEGINS.** Insurance under this Agreement will begin on the Effective Date if The Company's application for life insurance has been completed and a payment has been received by The Company for at least one-twelfth of the annual premium for the base plan and any supplementary benefits requested in the application. If payment is made by check or draft, no insurance will be provided by this Agreement unless the check or draft is honored when first presented for payment.
5. **TERMINATION AND REFUND OF PREMIUM.** Insurance under this Temporary Life Insurance Agreement will end on the earliest of:
   a) the 90th day after the date of this Agreement;
   b) the day before the date insurance takes effect under the policy applied for;
   c) the date The Company mails notice to the applicant either declining to offer insurance to the applicant or offering insurance on a basis other than as applied for.

   Upon termination of this Temporary Life Insurance Agreement, The Company's only liability will be to refund the premium paid without interest.
6. **SUICIDE.** If any person proposed for insurance, whether sane or insane, commits suicide, The Company's only liability will be to refund the premium paid without interest.
7. **MISREPRESENTATION.** If there is any material misrepresentation in the Temporary Life Insurance Agreement Application, The Company's only liability will be to refund the premium paid without interest.
8. **OTHER CONDITIONS.** No one is authorized to change or waive any provision of this Agreement

Give this page to the Owner

Notice of Protected Health Information Privacy Practices

John Hancock Life Insurance Company (U.S.A.)
John Hancock Life & Health Insurance Company
John Hancock Life Insurance Company of New York

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

We Respect Our Customers' Privacy

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

This Notice describes your rights concerning your "**Protected Health Information**" ("PHI") under the Health Insurance Portability and Accountability Act ("HIPAA"). Protected Health Information is information that may identify you and that relates to (a) your past, present, or future physical or mental health or condition or (b) the past, present or future payment for your health care. We collect medical information from long-term care, medical, and certain life insurance customers who purchased a long-term care rider, and sometimes from their medical providers, to make decisions about issuing coverage, charging premiums, and paying claims. This notice will describe how we may use and disclose this Protected Health Information.

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

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

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

Your Authorization To Use and Disclose Protected Health Information

We will not use or disclose your Protected Health Information without your written authorization unless the use or disclosure is described below in this notice. You have the right to revoke in writing at any time an authorization you give to us, by writing to us at the address listed at the end of this notice, but not if we have already acted in reliance on the authorization, nor if you provided the authorization in order to obtain your insurance coverage.

John Hancock does not sell or use your Protected Health Information for marketing purposes. We are required to inform you that uses and disclosures of Protected Health Information for marketing purposes (i.e. communications to individuals about health-related products or services where the insurer would receive financial remuneration in exchange for making the communication from or on behalf of a third party whose product or service is being described), and disclosures that constitute a sale of Protected Health Information would require your prior authorization.

Please give this Notice to the Proposed Insured.

Use And Disclosure Of Protected Health Information without Your Written Authorization

Below is a description of ways in which insurance companies, including John Hancock, are permitted to use and disclose the Protected Health Information we receive about you in connection with a long-term care insurance application, policy, certificate, or rider. These uses and disclosures, and those that are incidental to such uses and disclosures, are permitted by law without a signed authorization from you.

Use and disclosure for payment related purposes

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

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

The payment-related uses and disclosures that are permitted include:

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

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

Use and disclosure for health insurance operations

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

For example, when you apply for insurance, we may collect Protected Health Information from your doctor to determine if you qualify for insurance.

We may also use and disclose such information:

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

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

Use and disclosure for public health, government, or similar activities

We are permitted to disclose your Protected Health Information as described below, although we anticipate any such disclosure to be quite rare:

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

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

Disclosure to You and Individuals Involved in Your Care

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

We may also disclose your Protected Health Information for the treatment activities of a doctor or other health care professional.

Your Rights

You have certain rights concerning the Protected Health Information we have about you in our records, as described below.

Inspect and Copy

You have the right to inspect and obtain a paper or electronic copy of your Protected Health Information maintained in our records, but not psychotherapy notes nor information we compile in anticipation of a claim or legal proceeding.

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

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

If we do not maintain the Protected Health Information that you request, we will tell you where it is if we know.

Request Confidential Communications

You have the right to request that we send your Protected Health Information to you at a different address or by a means other than mail.

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

Amend

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

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

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

Accounting of Disclosures

You have the right to request an accounting of most disclosures we made of your Protected Health Information during the six years prior to the date the accounting is requested, subject to certain exceptions. To make such a request, please submit it in writing to the address at the end of this notice.

Request Restrictions on Use and Disclosure

You have the right to request that we restrict our use and disclosure of your Protected Health Information that otherwise would be permitted for purposes related to payment or our health insurance operations, or to your family, friends or others involved in your care or reimbursement for your care. We are not required to agree to such a restriction, and a restriction will not apply to disclosures to you or for certain public health or government purposes. If we agree to such a restriction, we will not use or disclose your medical information in violation of it except if you need emergency treatment, in which case we will request that your medical provider not further use or disclose it.

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

omplaints

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

Right to be Notified Following a Breach of Unsecured Protected Health Information

You have the right to and will receive a notification if John Hancock or one of its business associates has a breach of information security involving your unsecured Protected Health Information.

Effective Date

This Notice is effective May 31, 2013.

How to Contact Us

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

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

Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Be sure to include the following information in your request:

- your full name,
- address,
- date of birth,
- type of coverage (e.g., Long Term Care insurance policy or certificate, life insurance contract) and
- policy number if you purchased your policy or contract individually, or Group number and Reference ID number if you purchased a policy or certificate through your employer.

For further information regarding your policy, certificate, rider, or this Notice, please call us at:

Individual Long Term Care Insurance customers:	1-800-377-7311
Group Long Term Care Insurance customers:	1-800-525-4361
John Hancock Life Insurance customers:	1-800-387-2747
John Hancock Life Insurance Company of New York customers:	1-800-732-5543

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Important Notice: Replacement of Life Insurance or Annuities Appendix A – (NAIC Model Regulation)

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

This Important Notice 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 Individual Life Insurance.

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: IMPORTANT NOTICE: Replacement of Life Insurance or Annuities

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

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, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A **FINANCED PURCHASE** occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of, or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the following page.

3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ **Yes** ☐ **No**

4. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ **Yes** ☐ **No**

If you answered Yes to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	**INSURER NAME**
POLICY/CONTRACT NUMBER	**POLICY/CONTRACT NUMBER**
a. Insured(s)/Annuitant(s)	**a.** Insured(s)/Annuitant(s)
b. Owner	**b.** Owner
c. ☐ Annuity ☐ Life ☐ Term ☐ Endowment	**c.** ☐ Annuity ☐ Life ☐ Term ☐ Endowment
d. ☐ Replacement ☐ Financing	**d.** ☐ Replacement ☐ Financing
e. 1035 Exchange? ☐ Yes ☐ No	**e.** 1035 Exchange? ☐ Yes ☐ No
INSURER NAME	**INSURER NAME**
POLICY/CONTRACT NUMBER	**POLICY/CONTRACT NUMBER**
a. Insured(s)/Annuitant(s)	**a.** Insured(s)/Annuitant(s)
b. Owner	**b.** Owner
c. ☐ Annuity ☐ Life ☐ Term ☐ Endowment	**c.** ☐ Annuity ☐ Life ☐ Term ☐ Endowment
d. ☐ Replacement ☐ Financing	**d.** ☐ Replacement ☐ Financing
e. 1035 Exchange? ☐ Yes ☐ No	**e.** 1035 Exchange? ☐ Yes ☐ No

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. 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 in the sales presentation. Be sure that you are making an informed decision.

SECTION C: 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 or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract 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 or contracts. You should discuss the following with your agent 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 you 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? (See 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?

SECTION D: Agent Statement

5. 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.

SECTION E: Signatures

6. I do not want this notice read aloud to me. _____ **(Owner must initial only if they do not want the notice read aloud.)**
Initials

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

X _____ _____ _____
SIGNATURE OF OWNER | NAME OF OWNER (PLEASE PRINT) | DATE

X _____ _____ _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE | NAME OF AGENT/REGISTERED REPRESENTATIVE (PLEASE PRINT) | DATE

ADDITIONAL OWNERS SIGNATURES IF MULTIPLE OWNERS

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

X _____ _____ _____
SIGNATURE OF OWNER | NAME OF OWNER (PLEASE PRINT) | DATE

X _____ _____ _____
SIGNATURE OF OWNER | NAME OF OWNER (PLEASE PRINT) | DATE

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

External 1035 Exchange
Absolute Assignment/Beneficiary Change

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: Policy Information

- Complete one form per Issuing Company and Owner.
- If trust owned, provide full name of trust, name(s) of trustee(s) and date of trust.

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

POLICY NUMBER	OWNER	OWNER SSN/TIN	IS THERE A LOAN ON THE EXISTING POLICY?		IF YES, DO YOU WISH TO TRANSFER THE LOAN?	
			YES	NO	YES	NO
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

SECTION C: 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 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 health or circumstance and nothing else has occurred that would require a change to any statement or answer in any part of the application, including any supplemental forms ("Change in Insurability"), and subject to all of the other terms and conditions of the New Policy.
   b) It is vital to inform The Company of any Change in Insurability as soon as possible. If a Change in Insurability 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 a Change in Insurability 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 (i) 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, and (ii) shall not be required to issue any supplementary benefits applied for under the New Policy.

SECTION C: Exchanges to New Policy (continued)

3. c) Provided that no Change in Insurability occurred prior to the transmittal of this form to the Existing Insurer, if the proposed insured, or the surviving proposed 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.

   d) If the proposed insured, or the surviving proposed 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 distribution from the Existing Policy(ies) or the New Policy at the time of the exchange or within six months before or after the exchange will be reported to the Internal Revenue Service as a distribution that is taxable up to the amount of gain in such Existing Policy(ies) immediately prior to the assignment. The undersigned also understands that the use of policy value to repay a policy loan is a distribution and that any outstanding loan(s) on any Existing Policy(ies) at the time of the assignment will be treated as paid off by means of such a distribution unless the New Policy is subject to a loan in the same amount when it is issued. Unless the loan is carried over to the New Policy, the exchange will be partly taxable if there is any gain in the Existing Policy(ies).

10. Unless the Existing Policy(ies) are attached, I affirm that the Existing Policy(ies) has been destroyed or lost and that reasonable effort has been made to locate it. I agree that should the Existing Policy(ies) be found or in any way come into my possession, I will return the Existing Policy(ies) to John Hancock.

SECTION D: Signatures

X _____ _____

SIGNATURE OF OWNER
(IF CORPORATION, OFFICER(S) AND TITLE(S) MUST BE INDICATED)

DATE

X _____ _____

SIGNATURE OF OWNER
(IF CORPORATION, OFFICER(S) AND TITLE(S) MUST BE INDICATED)

DATE

X _____ _____

SIGNATURE OF SPOUSE
(IF ISSUE STATE IS A COMMUNITY PROPERTY STATE)

DATE

X _____ _____

SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

DATE

SECTION E: Confirmation - For Internal Use Only

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

_____ **X** _____

SIGNED THIS DAY OF YEAR

SIGNATURE OF COMPANY OFFICIAL

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

IMPORTANT NOTICE: Replacement of Long-Term Care Insurance

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SAVE THIS NOTICE. IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

SECTION B: IMPORTANT NOTICE: Replacement of Long-Term Care Insurance

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

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

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

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

SECTION C: Signature(s)

The above "IMPORTANT NOTICE: Replacement of Long-Term Care Insurance" was delivered to me on:

MONTH DAY YEAR

SIGNED AT CITY STATE THIS DAY OF YEAR

X SIGNATURE OF PROPOSED INSURED

NAME OF PROPOSED INSURED - PLEASE PRINT

X SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

NAME OF AGENT/REGISTERED REPRESENTATIVE - PLEASE PRINT

Please provide the Proposed Insured with a copy.

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Application Supplement: Individual Insurance Long-Term Care Rider

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

(hereinafter referred to as The Company)

- This form is part of the Application for Life Insurance for the Proposed Insured.
- Print and use black ink. Any changes must be initialed by the Owner(s) and Proposed Insured.
- Complete in all cases when electing the Acceleration of Death Benefit for Qualified Long-Term Care Services rider (the "Rider").
- Attach an additional page signed by the Owner(s) and Proposed Insured if more space is required.

Proposed Insured

1. Name First Middle Last

OWNER - Complete information only if Owner is other than Proposed Insured

2. Name First Middle Last

MONTHLY ACCELERATION PERCENTAGE/ACCELERATED BENEFIT PERCENTAGE

3. ☐ Choose a Monthly Acceleration Percentage ☐ *1%* ☐ *2%* ☐ *4%*
   ☐ Choose an Accelerated Benefit Percentage _____*% (1.00% - 100.00%)*

PROTECTION AGAINST UNINTENTIONAL LAPSE

4. I, the Owner, understand that I have the right to designate at least one person other than myself to receive Notice of Lapse/Termination of this Rider 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 NOT to designate a person(s) to receive such Notice of Lapse/Termination.
   ☐ I elect the following person(s) to receive Notice of Lapse/Termination of this Rider for non-payment of premium.

Name	Address – Street Name, Apt No	City, State, Zip Code

INSURANCE HISTORY - To be answered by the Proposed Insured

5. a) Is there currently, or has there been during the last 12 months, another accident and health or long-term care insurance policy or certificate in force on the Proposed Insured (including health care service contracts or health maintenance organization contracts)? ☐ Yes ☐ No
   b) Are there any other life insurance or individual long-term care insurance policies or certificates currently in force that provide similar long-term care coverage on the Proposed Insured? ☐ Yes ☐ No
   c) Will any long-term care, medical or health coverage on the Proposed Insured be replaced with the Rider coverage applied for hereunder? ☐ Yes ☐ No

Details for "Yes" Answer to questions 5. a) - 5. c)

Company	Policy/Certificate No	Type and Amount of Benefits	Currently inforce?		Is it being replaced?	
			Yes	No (lapse date)	Yes	No
			☐	☐ (_____)	☐	☐
			☐	☐ (_____)	☐	☐
			☐	☐ (_____)	☐	☐

d) Is the Proposed Insured covered by Medicaid? ☐ Yes ☐ No

e) Within the past 5 years has the Proposed Insured received or applied for Social Security Disability Insurance, Medicaid or any other form of disability benefit? ☐ Yes ☐ No

Type _____ Percentage _____% Reason _____

f) Has the Proposed Insured been declined or rated for long-term care coverage? ☐ Yes ☐ No

Reason _____

HEALTH QUESTIONS - To be answered by the Proposed Insured

6. a) Within the past 5 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions? ☐ Yes ☐ No
(If **Yes**, check all that apply)
i) ☐ Alzheimer's Disease ☐ Cognitive Impairment ☐ Dementia ☐ Memory Loss
ii) Progressive visual disorders, such as: ☐ Glaucoma ☐ Macular Degeneration ☐ Retinitis Pigmentosa

b) Do you currently need, or within the past 5 years have you needed or required assistance or supervision while performing the following activities due to any impairment, whether physical or mental? ☐ Yes ☐ No
(If **Yes**, check all that apply)
i) ☐ housekeeping ☐ meal preparation ☐ laundry ☐ shopping ☐ telephone use
☐ managing your finances ☐ taking your medication
ii) ☐ bathing ☐ dressing ☐ eating ☐ toileting ☐ transferring in or out of bed or a chair
☐ controlling your bowel or bladder

c) Do you currently use any of the following assistance devices? ☐ Yes ☐ No
(If **Yes**, check all that apply)
i) ☐ a cane (any type) ☐ walker ☐ wheelchair ☐ motorized scooter ☐ crutches ☐ stairlift
ii) ☐ home intravenous medications ☐ respirator ☐ feeding tube ☐ shunt
☐ port-a-catheter ☐ hospital bed ☐ dialysis machine ☐ personal oxygen system

d) Within the past 5 years, have you been confined to, or received medical advice by a member of the medical profession to be admitted to, or received services from any of the following? ☐ Yes ☐ No
(If **Yes**, check all that apply)
i) ☐ nursing home ☐ assisted living facility ☐ other custodial facility
ii) ☐ home health care
iii) ☐ adult day care

Details for "Yes" Answers

Question No.	Date (Month/Day/Year)	Reason	Duration of Condition	Name, Address and Telephone number of Attending Doctor and Hospital

DECLARATIONS AND ACKNOWLEDGMENT

I/We, the Owner(s) and Proposed Insured, declare that I/we have read the answers and statements in this application supplement and to the best of my/our knowledge and belief, they are true, complete and have been correctly recorded.
I/We understand that the answers and statements in Application for Life Insurance, which includes this application supplement and any other supplemental forms, will form the basis of any insurance coverage issued as a result of such application. I/We also understand that no information about the Owner or the Insured will be considered to have been given to John Hancock Life Insurance Company unless it is stated in the application.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.) MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I, the Owner(s) acknowledge that I (we) have received the Outline of Coverage and a Replacement Notice (if a replacement is involved). I (We) agree that an agent or medical examiner does not have John Hancock Life Insurance Company's authorization to accept risk, pass on insurability, or make, void, waive or change any questions, conditions, or provisions of the application or rider.

X _____
Signature of Owner

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

X _____
Signature of Proposed Insured if other than Owner

X _____ _____
Signature of Agent/Registered Representative Date

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Third-Party Ownership Disclosure – Long-Term Care Riders

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SECTION A: Proposed Life Insured or Life Insured

1. a) Name FIRST MIDDLE LAST | b) Policy Number (If known)

SECTION B: Applicant (Owner) or Proposed Owner

2. Name FIRST MIDDLE LAST

The Company is a provider of life insurance policies and related products; as such, The Company does not provide legal or tax advice regarding any potential ownership arrangement for our products. We understand, however, that under certain circumstances you and your tax and legal advisors may determine that it is in your best interests for a life insurance policy with a long-term care rider to be owned by a third party (i.e., someone other than the Life Insured). The Company cannot provide you with tax advice and urges you to obtain independent advice on the tax issues described below.

We caution you that, although there are arguments for favorable tax treatment of policies with the long-term care rider when they are owned by a third party, there is little guidance from the Internal Revenue Service as to the tax effects of such third-party ownership. Given the current lack of guidance regarding the ramifications of third-party ownership, there is the risk that such ownership structure could cause adverse income, estate and/or gift tax consequences. Therefore, we encourage you and your tax and legal counsel to review the particulars of your intended ownership arrangement in light of the income, gift, and estate tax provisions of the Internal Revenue Code.

In addition, when long-term care benefits are paid out under the long-term care insurance rider, those benefits are paid to the owner of the life insurance policy and not to the Life Insured. A third-party ownership structure with the long-term care insurance rider means that the long-term care insurance benefits under the rider are not paid to the Life Insured.

You should obtain independent advice tailored to the facts of your particular situation. A life insurance policy with a long-term care rider should only be purchased by or transferred to a person other than the Life Insured after all parties have carefully reviewed the issues with their own tax and legal advisors.

SECTION C: Signatures

I have read and understood the foregoing disclosure, and to the extent I consider necessary, I have discussed it with my tax and legal advisors. I am not relying on tax advice provided by The Company or by its employees or representatives.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____
SIGNATURE OF PROPOSED LIFE INSURED OR LIFE INSURED

X _____
SIGNATURE OF APPLICANT (OWNER) OR PROPOSED OWNER

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

Life Post Issue, John Hancock
Life Insurance Company (U.S.A.)
410 University Ave, Suite 55765
Westwood, MA 02090
1-800-387-2747

ACCELERATION OF DEATH BENEFIT FOR QUALIFIED LONG-TERM CARE SERVICES RIDER OUTLINE OF COVERAGE – Form ICC20 18LTCR

CAUTION: The issuance of this rider is based upon our issuance of the policy and the responses to the questions on the application for this rider and the policy. A copy of the application for the policy and for this rider is attached to the policy. If the answers are incomplete, untrue, or not correctly recorded, we have the right to deny benefits or rescind this rider subject to the provisions of this rider and the policy. The best time to clear up any questions is now, before a claim arises! Contact the Company by writing to us: **Life Post Issue, John Hancock Life Insurance Company (U.S.A.), 410 University Ave, Suite 55765, Westwood, MA 02090** or calling us: **1-800-387-2747**.

NOTICE TO BUYER: This rider may not cover all of the costs associated with long-term care that the Insured incurs during the period of coverage. You are advised to carefully review all benefit limitations.

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

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

   This Outline of Coverage provides a very brief description of the important features of this rider. You and the Insured should compare this Outline of Coverage to outlines of coverage for other policies or riders available to you. This is not an insurance contract, but only a summary of coverage. Only the policy and rider contain governing contractual provisions. This means that the policy and rider set forth, in detail, the rights and obligations of both you and the 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 THIS RIDER.**

   This rider is intended to be a qualified long-term care insurance contract under Internal Revenue Code ("Code") section 7702B(b). The benefits provided by this rider are designed to be excludable from gross income under federal tax law; however, there might be situations in which the benefits or charges for this rider are taxable. If, in the future, it is determined that this rider does not meet the requirements of Code section 7702B, we will make reasonable efforts to amend this rider, if we are required to do so, to maintain this rider's tax status. We will offer you an opportunity to receive these amendments. If you choose to reject these amendments, this rider may no longer be a qualified long-term care insurance contract under section 7702B(b). If you have any questions concerning the tax implications of this rider, you should consult with an attorney or a qualified tax advisor.

4. **TERMS UNDER WHICH THE POLICY 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 this rider, to continue this rider as long as you pay the monthly Rider Charge when due. In addition, we cannot increase the rates used for determining the charges for this rider.

   (b) **WAIVER OF PREMIUM**

   If the policy contains a rider that waives the Monthly Deductions on the policy in accordance with that rider, we will waive the charges for this rider as well.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE CHARGES**

We cannot increase the rates used for determining the charges for this rider.

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

(a) **THIRTY DAY FREE LOOK**

If you are not completely satisfied with this rider for any reason, you may return it within 30 days from the date it was delivered to you. To return this rider, mail or deliver it to: the agent who sold it to you, our Service Office, or the agency office through which it was delivered. We will refund in full the payment made applicable to this rider directly to the payer within 30 days following receipt of the returned rider. This rider will be treated as if it had never been issued.

(b) **REFUND OF UNEARNED PREMIUMS**

Upon receipt of notice that the Insured has died, we will reverse any monthly Rider Charge(s) deducted for this rider for any period beyond the date of death.

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

If you are 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**

This long-term care rider is designed to cover care or services specified in the Insured's Plan of Care such as Home Health Care, Adult Day Care, Hospice Care, Stay at Home Services, and care provided in a Nursing Home or Assisted Living Facility, but not in an acute care unit of a hospital. Please see **Accelerated Benefits Provided by This Rider**, below.

This rider provides Accelerated Benefits for actual charges incurred, up to the Maximum Monthly Benefit Amount and the Stay at Home Lifetime Benefit Amount, for covered long-term care expenses, subject to rider limitations and requirements.

9. **ACCELERATED BENEFITS PROVIDED BY THIS RIDER**

(a) COVERED SERVICES

Subject to the conditions, limitations, and exceptions found in this rider, we will pay Accelerated Benefits for the reimbursement of actual charges incurred for receipt of Qualified Long-Term Care Services in relation to:

- 24-hour confinement in a Nursing Home or Assisted Living Facility for room, board, and care services (such care services being Nursing Care, Custodial Care, and Hospice Care);
- Home Health Care provided by a Home Health Care Agency;
- Hospice Care;
- Stay at Home Services; or
- attendance at an Adult Day Care Center providing Adult Day Care.

(b) ACCELERATED BENEFITS

Subject to the conditions, limitations, and exceptions found in this rider, we will pay Accelerated Benefits on a monthly basis in an amount not to exceed the least of (a), (b) or (c), where: (a) is the sum of (i) and (ii), where: (i) is the lesser of charges incurred by the Insured for Qualified Long-Term Care Services (excluding charges for Stay at Home Services) for the calendar month and the Maximum Monthly Benefit Amount; and (ii) is the lesser of charges incurred by the Insured for Qualified Long-Term Care Services for the calendar month and the Stay at Home Lifetime Benefit Amount; (b) is the amount you request, or (c) the remaining Accelerated Benefit Balance. The Accelerated Benefit will be payable provided the requirements for

Eligibility for Accelerated Benefits have been satisfied and Proof of Loss documentation for Qualified Long-Term Care Services has been provided, as described below.

Each Accelerated Benefit payment is based upon a calendar month time period. If, at the time we pay an Accelerated Benefit, there is an outstanding Policy Loan, a portion of the Accelerated Benefit will be deemed a loan repayment and will reduce the Accelerated Benefit otherwise payable for that period.

(c) Eligibility for Payment of Benefits

The following conditions must be satisfied in order for you to be eligible to receive Accelerated Benefits:

- the rider must be In Force;
- you provide us with Written Certification that the Insured is a Chronically Ill individual;
- the Insured has satisfied the Elimination Period;
- we receive a current Plan of Care and written Proof of Loss; and
- the Insured was alive and received Qualified Long-Term Care Services that are consistent with and specified in the Insured's Plan of Care while this rider is In Force.

Chronically Ill Individual means an Insured who has provided Written Certification from a Licensed Health Care Practitioner that he or she requires:

- Substantial Assistance from an individual to perform at least 2 Activities of Daily Living, due to the loss of functional capacity, for a period expected to last at least 90 days; or
- Substantial Supervision to protect against threats to health and safety due to a Severe Cognitive Impairment.

Activities of Daily Living means the 6 activities listed below:

(i) *Bathing* which means washing oneself by sponge bath, in a tub or a shower, including the task of getting in or out of the tub or shower.

(ii) *Continence* which means the ability to maintain control of bowel and bladder function, and, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or a colostomy bag).

(iii) *Dressing* which means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.

(iv) *Eating* which means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or being fed by a feeding tube or intravenously. Eating does not include preparing a meal.

(v) *Toileting* which means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(vi) *Transferring* which means moving into or out of a bed, chair, or wheelchair. Transferring does not include the task of getting into or out of the tub or shower or mobility outside the Insured's place of residence.

Medication management, the management of financial affairs, assistance with the telephone and clinical interventions (such as but not limited to blood and/or glucose monitoring, or assistance in putting on and/or taking off compression stockings) are not Activities of Daily Living.

Severe Cognitive Impairment means a deficiency in the Insured'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 days shown in the Policy Specifications for this rider from the date of Written Certification that the Insured is a Chronically Ill Individual. We will not pay any Accelerated Benefits under this rider until the Elimination Period has been satisfied. We will not pay Accelerated Benefits for any Qualified Long-Term Care Services incurred during the Elimination Period.

Only one complete Elimination Period needs to be satisfied while the rider is In Force.

10. **LIMITATIONS AND EXCEPTIONS**

In addition to the conditions set forth above, the following limitations and exceptions apply to this rider.

(a) EXCLUSIONS

This rider does not pay for care or treatment:

- due to intentionally self-inflicted injury;
- due to suicide or attempted suicide, while sane or insane;
- required as a result of alcoholism or drug addiction;
- due to war (declared or undeclared) or any act of war, or active duty in of the armed forces or auxiliary units;
- due to participation in a felony, riot, or insurrection;
- normally not provided or made in the absence of insurance;
- received outside of the 50 United States and the District of Columbia;
- provided by a Nursing Home, Assisted Living Facility, Home Health Care Agency, or Adult Day Care Center that is owned and operated by a member of your or the Insured's Immediate Family; or
- provided by a member of your or the Insured's Immediate Family.

(b) NON-DUPLICATION OF BENEFITS

This rider will only reimburse charges for Qualified Long-Term Care Services in excess of charges paid, reimbursed, or considered deductibles or coinsurance under any of the following:

- Medicare, including amounts not reimbursable by Medicare such as Medicare deductible or coinsurance amounts;
- any other governmental program (except Medicaid); or
- any workers' compensation law, employer's liability or occupational disease law, or any motor vehicle no-fault law.

(c) CHARGES NOT COVERED

We will not pay for any of the following charges incurred by the Insured: Physician's charges; private duty nurse when the Insured is inpatient confined in a Nursing Home or Assisted Living Facility; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; home modifications and durable medical equipment (excluding for Stay at Home Services); shipping charges; any transportation or mileage charge; items and services furnished for beautification, comfort, convenience, or entertainment; room and board charges or entrance fee for independent living quarters in a continuing care retirement community, rest home, or similar entity; any type of residential upkeep, construction, renovation, or home maintenance (such as painting or plumbing); lawn/yard care; snow removal; vehicle or equipment upkeep; charges for Home Health Care provided outside the Home; hotel, cruise ship or similar charges incurred by the Insured, an Immediate Family member or care provider; and charges for care or services which are not included in and/or are inconsistent with the Insured's Plan of Care.

(d) LIMITATIONS ON THE ELIGIBILITY FOR PAYMENT OF ACCELERATED BENEFITS

We will only pay benefits under this rider for those Qualified Long-Term Care Services specified in the Plan of Care.

THIS RIDER MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH THE INSURED'S 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 and the Insured should consider whether and how the benefits of this rider should be used. ***This rider does not include inflation protection coverage.*** Decreases to the Death Benefit of the policy resulting from the exercise of the rights thereunder, including the right to take withdrawals, will reduce the Maximum Monthly Benefit Amount and the amount payable upon the Insured's death. If there is a Policy Loan, a portion of the Accelerated Benefit will be deemed a loan repayment and will reduce the Accelerated Benefit payable to you and the amount payable upon the Insured's death.

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

This rider provides reimbursement for Qualified Long-Term Care Services required as a result of a degenerative brain disorder with demonstrable organic cause (including Alzheimer's disease and similar forms of senility and irreversible dementia) that result in the Insured's Severe Cognitive Impairment.

13. **RIDER CHARGE**

There is a monthly charge for this rider. The charge will cease at the Insured's Age 100. The charge for this rider is the Monthly Rider Rate multiplied by the greater of $0.00 and the Rider Net Amount at Risk divided by 1,000. See **Policy Specifications**.

The Rider Net Amount at Risk is (a) multiplied by (b) multiplied by (c), where:

(a) is the Accelerated Benefit Balance; and
(b) is (i) minus (ii), where:
    (i) is 1 divided by the Death Benefit Discount Factor; and
    (ii) is the ratio of the Policy Value divided by the Life Insurance Death Benefit, both determined immediately after the deduction of all other charges due on that date;
(c) is the Rider Charge Adjustment Factor. See **Policy Specifications**.

If the policy contains a Death Benefit Protection provision, the Rider Charge deducted from the Death Benefit Protection Value is calculated in the same manner as described above except that the Rider Charge Adjustment Factor is equal to 1 and the Death Benefit Protection Value is used instead of the Policy Value in the Rider Net Amount at Risk calculation.

14. **ADDITIONAL FEATURES**

(a) MEDICAL UNDERWRITING

Issuance of this rider may depend upon certain medical information about the Insured. This is generally known as medical underwriting.

(b) EFFECT OF ACCELERATED BENEFITS ON THE POLICY

This rider interacts with the policy to which it is attached. Each payment of Accelerated Benefits reduces the Face Amount of the policy and 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 Accelerated Benefits paid and the effect of such payments on the policy's values. Accelerated Benefits under this rider affect the policy as follows:

- **Death Benefit and Face Amount.** Each payment of Accelerated Benefits reduces the Face Amount, resulting in a new Face Amount.
- **Policy Value.** Each payment of Accelerated Benefits reduces the Policy Value, resulting a new Policy Value. If the policy contains a Death Benefit Protection provision, Persistency Credit provision, or Cumulative Guarantee provision, each Accelerated Benefit payment reduces the Death Benefit Protect Value, Persistency Measure, and the Cumulative Guarantee Policy Value by the same proportion by which the Policy Value is reduced.
- **Surrender Charges.** If the policy imposes a Surrender Charge for a reduction in Face Amount, such charge will be waived for Accelerated Benefits payments.
- **Loans.** If, at the time we pay an Accelerated Benefit, there is an outstanding Policy Loan, a portion of the Accelerated Benefit will be deemed a loan repayment and will reduce the Accelerated Benefit otherwise payable.
- **Restrictions on Transfers.** If this rider is attached to an indexed universal life insurance policy or a variable universal life insurance policy, and you are receiving Accelerated Benefits under this rider, we will transfer any Policy Value from your Index Accounts or Investment Accounts to the Guaranteed Interest Account or Fixed Account, respectively. Such transfers will be made at the end of the Segment Period or Valuation Date following payment of your claim. While you are receiving Accelerated Benefits, you will not be able to allocate Policy Value or future premium payments to any Indexed Account or Investment Account.

(c) EFFECT OF POLICY CHANGES ON THE ACCELERATED BENEFIT POOL

- **Withdrawals and Face Amount Reductions.** Any withdrawal or reduction in Face Amount (whether requested or due to coverage lapse) is considered a Policy Change and will reduce the Accelerated Benefit Pool, resulting in a new Maximum Monthly Benefit Amount. Such reduction will be effective as of the effective date of the withdrawal or reduction in the Face Amount.

(d) EFFECT OF TERMINAL ILLNESS RIDER

- **Terminal Illness.** Any benefits payable under a Terminal Illness rider reduce the benefits available under this rider.

15. **CONTACT THE STATE AGENCY LISTED IN THE NAIC'S *A SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* 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 COVERAGE.**

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

PART II Medical Supplement

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

This form is part of the Application for Individual Life Insurance.

If a Survivorship policy is applied for, a separate Part II Medical Supplement form will need to be completed by each Proposed Insured.

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

The information you provide in this application is critical to our consideration of your request for insurance coverage. You are strongly urged to answer all questions completely and accurately so that we may provide you with the best coverage we can. We will seek information from other sources to assist us with evaluating your application, potentially including your health care provider. If your answers are incorrect, incomplete or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage. Please know that your personal information, including health information, is protected by The Company and only used by The Company to do business with you, and as permitted or required by law.

SECTION A: General Information

Any information that requires more space or further detail can be added in *SECTION G: ADDITIONAL INFORMATION*

1. Name FIRST MIDDLE LAST

2. Date of Birth	3. Social Security Number	4. Sex
MONTH DAY YEAR		☐ Male ☐ Female

5. Family History: *Please provide the following details concerning your biological family history to the best of your knowledge.*

FAMILY MEMBER	• Indicate any diagnosis and age of onset, if any of your immediate family members have ever been diagnosed by a member of the medical profession with Cancer, Coronary Artery Disease, Stroke, Diabetes, Huntington's, Alzheimer's, or Polycystic Kidney Disease. • Provide health status/medical condition if living.	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS/SISTERS ☐ No siblings				

SECTION A: General Information (continued)

! Only complete questions 6, 7, 8, and 9 if the Proposed Insured is age 60 or UNDER.

6. a. Provide your height: _____ feet _____ inches | b. Provide your weight: _____ pounds

7. a. Have you had any weight loss of 10 lbs. or more in the past 12 months?
☐ Yes – specify lbs.: _____ ☐ No

b. In the past 12 months have you tried to lose weight through diet or exercise?
☐ Yes ☐ No

c. Have you had any weight gain of 10 lbs. or more in the past 12 months?
☐ Yes – specify lbs.: _____ ☐ No

8. What was your last blood pressure reading? _____ / _____ ☐ Unknown

9. What was your last cholesterol reading? Total Cholesterol: _____ HDL: _____ ☐ Unknown

SECTION B: Medications

If you need more space for information, please continue to *SECTION G: ADDITIONAL INFORMATION*

10. List all medications you have taken or been prescribed in the last 12 months and the conditions for which they are being taken.

PRESCRIPTION NAME	CONDITIONS FOR WHICH THIS MEDICATION IS TAKEN

☐ I have not been prescribed any medications in the last 12 months

SECTION C: Medical Conditions

Any information that requires more space or further detail can be added in *SECTION F: ADDITIONAL MEDICAL CONDITIONS DETAILS*

11. In the last 5 years, have you been diagnosed, treated or consulted with a member of the medical profession for any of the following medical conditions?

Check all that apply and provide complete details.

MEDICAL CONDITIONS

a. ☐ High Blood Pressure
☐ High Cholesterol
☐ Coronary Artery Disease
☐ Heart Attack
☐ Cardiac Chest Pains
☐ Arrhythmia/Irregular Heart Beat
☐ Heart Murmur/Valvular Heart Disease
☐ Heart Failure
☐ Peripheral Vascular Disease
☐ Stroke/Transient Ischemic Attack (TIA)
☐ Other Disorders of the Heart or Blood Vessels
☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: _____

CONDITION NAME/DIAGNOSIS

DATE OF ONSET
MONTH YEAR

TREATMENT GIVEN

DURATION OF CONDITION

PHYSICIAN NAME ADDRESS PHONE NUMBER

HOSPITAL NAME ADDRESS PHONE NUMBER

QUESTION 11 *continues on next page*

SECTION C: Medical Conditions (continued)

MEDICAL CONDITIONS

b. ☐ Diabetes
   ☐ High Blood Sugar/Glucose Intolerance/Pre-Diabetes
   ☐ Disorders of the Thyroid or Other Glands
   ☐ None of these apply to me

c. ☐ Cancer
   ☐ Leukemia/Lymphoma
   ☐ Benign Tumor/Polyp
   ☐ Malignant Tumor/Polyp
   ☐ Malignant Melanoma
   ☐ None of these apply to me

d. ☐ Anemia/Blood Disorder
   ☐ Autoimmune Disorder
   ☐ None of these apply to me

e. ☐ Asthma
   ☐ Emphysema/COPD/Chronic Bronchitis
   ☐ Sleep Apnea
   ☐ Other Respiratory/Lung Disorders
   ☐ None of these apply to me

f. ☐ Seizures/Epilepsy
   ☐ Tremors
   ☐ Paralysis
   ☐ Parkinson's disease
   ☐ Multiple Sclerosis
   ☐ Cognitive Impairment/Memory Loss
   ☐ Alzheimer's Disease/Dementia
   ☐ Other Nervous System or Neurological Disorders
   ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION 11 *continues on next page*

SECTION C: Medical Conditions (continued)

MEDICAL CONDITIONS

g. ☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ Other Psychological or Mental Health Disorders
☐ None of these apply to me

h. ☐ Ulcers
☐ Hepatitis
☐ Cirrhosis
☐ Crohn's/Ulcerative Colitis
☐ Barrett's Esophagus
☐ Other Disorders of the Liver, Gallbladder, Esophagus, Pancreas, Stomach, or Intestines
☐ None of these apply to me

i. ☐ Rheumatoid/Psoriatic Arthritis
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Fractures
☐ Amputation
☐ Other Bone, Joint, Muscle, or Connective Tissue Disorders
☐ None of these apply to me

j. ☐ Kidney Disease
☐ Disorders of the Bladder or Urinary Tract
☐ Disorders of the Prostate
☐ Disorders of the Breast
☐ Disorders of the Reproductive Organs
☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

SECTION D: Medical Conditions and Diagnostic Tests

- For questions 12, 13, and 14, you do not need to tell us about: muscle strains, sprains, limb fractures that you have fully recovered from, normal childbirth, colds, flu, appendicitis, seasonal asthma, vasectomy, tonsillitis, conjunctivitis, or hay fever
- Provide complete details to any 'yes' responses
- If you need more space for information, please continue to *SECTION G: ADDITIONAL INFORMATION*

12. Completed Diagnostic Testing: Within the past 2 years have you undergone any diagnostic tests (e.g. Blood, urine, EKGs, X-rays, screening tests for family history) excluding HIV, whether conducted on an inpatient or out-patient basis?

☐ Yes ☐ No

If Yes, give details _____

13. Pending Tests or Procedures: In the past 2 years have you been advised by a member of the medical profession to have any surgery, procedure, treatment or diagnostic testing (including any screening tests for family history, but excluding those for HIV), other than for routine screening purposes that have not yet been completed or results which have not yet been received?

☐ Yes ☐ No

If Yes, give details _____

14. Other than what has already been asked, within the last 5 years have you been treated, consulted, or given medical advice by a member of the medical profession in any hospital, emergency room, urgent care or medical facility for any disease, disorder, symptoms, or injury not previously mentioned?

☐ Yes ☐ No

If Yes, give details _____

15. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?

☐ Yes ☐ No

If Yes, give details _____

SECTION E: Personal Information

16. Describe your present alcohol consumption.

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

If consumption exceeds the allotted space below, list remainder in SECTION G: ADDITIONAL INFORMATION

TYPE OF BEVERAGE	AMOUNT (# OF DRINKS) AND FREQUENCY	DATE LAST USED (MONTH/YEAR)
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR

☐ I have not consumed alcohol in the past 10 years

17. In the past 10 years have you been advised to limit or discontinue alcohol use, or sought or received counseling or treatment by a member of the medical profession for alcohol use?	☐ Yes ☐ No
18. Within the last 10 years have you used, or tested positive by a member of the medical profession for:	
a. Cocaine, heroin, amphetamines, or hallucinogens?	☐ Yes ☐ No
b. Tranquilizers, sedatives or narcotic drugs or any prescription drug except those used in accordance with physician's instructions?	☐ Yes ☐ No
19. In the past 10 years have you sought or received treatment by a medical professional, counseling or participated in a support group for drug use?	☐ Yes ☐ No

If YES to questions 17, 18 or 19 please provide details:

SECTION F: Additional Medical Conditions Details

This is additional space if required for conditions identified in question 11 A - J

QUESTION NUMBER	CONDITION NAME/DIAGNOSIS	DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER	CONDITION NAME/DIAGNOSIS	DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

SECTION G: Additional Information

This is additional space if required for any of the previous questions

QUESTION NUMBER	DETAILS

Read previous pages carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me.

2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, the MIB, Inc. ("MIB") or any other similar person or organization to disclose health information about me or any minor child who is to be insured. Health information includes: (i) my entire medical record and medical history, prescription history, and other health information; (ii) confidential information related to Human Immunodeficiency Virus (HIV), other communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to disclose financial/ net worth information about me.

Such disclosure of my information may be made to The Company, its affiliated companies, agents, service providers, reinsurers, MIB or any person or entity entitled to receive such information by law or as I may further consent.

Information collected under this authorization will be used to evaluate my application for insurance, identify any misrepresentation in the information provided by me in this application, administer coverage, evaluate a claim for benefits, for reinsurance or other insurance purposes, or to conduct other legally permissible activities. I authorize The Company, or its reinsurers, to make a brief report of my health information to MIB.

This authorization is valid for 24 months from the date shown below or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter. A photocopy of this authorization will be as valid as the original. I am entitled, or my authorized representative is entitled, to a copy of this authorization.

I understand that I can revoke this permission to collect information at any time by providing written notification to John Hancock Life Insurance Company (U.S.A.) at the Service Office address (page 1) Attention: Chief Underwriter, but any revocation will not affect such information that has already been collected and relied on by The Company.

SIGNATURES

I have read the statements and answers on this Part II Medical Supplement, and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for which this information was required by The Company.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF PROPOSED INSURED (PARENT OR GUARDIAN IF UNDER AGE 15)

X _____

SIGNATURE OF EXAMINER (IF APPLICABLE)

Privacy Notice

OUR PRIVACY COMMITMENT TO YOU

John Hancock respects your privacy. Your trust is one of our most valuable assets. One way we hope to keep your trust is by properly protecting your personal information.

What Does This Notice Cover?

This Notice describes our privacy policy and how we handle our customers' and former customers' personal information pursuant to applicable law.

For information on how John Hancock uses the data collected from visitors of John Hancock websites, social media sites and mobile applications, please refer to the John Hancock Statement Regarding Online Privacy.

For information on your rights concerning your Protected Health Information under the Health Insurance Portability and Accountability Act, please refer to our HIPAA Notice of Protected Health Information Privacy Practices.

If you live in Europe, please refer to our Privacy Notice for European Residents for information on your rights under the General Data Protection Regulation.

These notices can be found at **www.johnhancock.com/privacy**.

Why Do We Collect Your Personal Information?

Collecting personal information about you helps us provide you with quality products and services. It also helps us to confirm your identity, prevent fraud, and fulfill legal and regulatory requirements. The type of information we collect depends on the products or services you have with us.

We obtain personal information from you when you submit an application or other similar forms, as well as from transactions and other interactions with you. This information may include:

- Personal data, such as name, address, email address, telephone number, date of birth, Social Security number, and citizenship;
- Financial data, such as income, assets, banking information, credit card information, and investment preferences;
- Health data, such as medical, biometric, and health-related information and habits;
- Interaction data collected when you visit or use our websites, mobile applications, and social media sites, or when you call our call centers.

We may also obtain information from third parties and publicly available sources. For example, your insurance agent, broker, registered representative, or financial advisor, consumer reporting agencies, medical providers, data service providers, social media services, commercially available sources, business partners, and insurance support agencies (such as the MIB, Inc.).

How Do We Protect The Personal Information We Have Collected About You?

Our employees respect your personal information. They are trained to keep it safe. We have administrative, physical, and technical safeguards in place that are designed to protect your information.

How Do We Use and Share The Personal Information We Have Collected About You?

All financial services companies need to use and share customers' personal information in order to provide services to them. We use your personal information mainly to communicate with you, complete transactions that you have requested or authorized, administer your policy or account, and to make you aware of additional products and services that we offer.

As permitted or required by applicable law, your personal information may be shared:

- with employees and associates when their jobs require it to process and service your contracts, benefits, or accounts;
- with your financial advisor, representative, or firm in order for them to service your policy or account;
- with third parties performing services on our behalf. They are contractually bound to use your information only to perform those services. They are required to have safeguards in place to protect it, and are not permitted to use or disclose your information for their own marketing purposes;
- with companies from which we purchase reinsurance coverage;
- to conduct routine or required activities such as audits and tax filings;
- to participate in research studies or to conduct surveys;
- in response to subpoenas and court orders, or to comply with legal requests made by law enforcement and regulatory authorities.

We do not sell your personal information. We do not share it with any unaffiliated company for the purpose of that company marketing its products or services to you.

We may share it with unaffiliated financial services companies to jointly market or offer products or services that may be of interest to you.

Except as noted below, we may share your information within the John Hancock affiliated companies listed at the end of this notice to provide you with offers for other John Hancock products or services. You have the right to opt out of that information sharing.

If you are a client of John Hancock Investment Management, LLC or have coverage under an employer-sponsored retirement plan, group pension contract, group annuity contract or group insurance policy, we do not share your personal information, other than as necessary to provide services or administer your coverage.

How Can You Opt Out?

If you do not want us to share your personal information with our affiliated companies for their own marketing purposes, you may opt out of that information sharing at **www.johnhancock.com/contactpreferences.** You may also opt out by calling or writing to the contact information provided in the "Contacting Us" section below.

Your request will take effect within 30 days of the date it was received. If you have more than one John Hancock product you only need to opt out once. Once you opt out, we will honor your choice until you ask us to change it. If you are the joint owner of a product and you tell us not to share information, you may elect to have your choice applied to all owners of that product. If you have already exercised your right to opt out, there is no need to contact us again.

We will continue to send you information about your contracts, benefits, and accounts. We may also include information about other John Hancock products or services. Opting out will not affect the ability of your financial advisor, representative, or firm to recommend products or services to you.

How Can You Review Your Personal Information?

Generally, you have the right to review personal information we have obtained about you. Requests to obtain a copy of your personal information must be made in writing and signed by you or your legal representative.

The request must include your:

- full name
- address
- product type (e.g. life insurance, annuity, mutual fund, etc.)
- policy contract or account number

If you believe that information we have obtained about you is incorrect, you may write us and request a correction. If we agree with your request, we will correct your information. If we do not agree, we will let you know. Then, you may write us to dispute our decision. We will keep all of your correspondence in our files.

Contacting Us

If you have a question about your account, or if you want to review the information we have on file about you, please contact us at:

John Hancock Insurance Services
Life - Post Issue
PO Box 55979
Boston, MA 02205-5979

Telephone:
1-800-387-2747 John Hancock
1-888-267-7781 John Hancock Life Insurance Company of New York

If you have a question about this Privacy Notice, please contact the John Hancock Privacy Office.

Mailing Address: John Hancock Privacy Office
U.S. Compliance Department
197 Clarendon Street, C-5
Boston, MA 02116

Email Address: **Privacy@jhancock.com**

You may obtain information about the Securities Investor Protection Corporation (SIPC), including a SIPC brochure, by contacting SIPC at **www.sipc.org** or 1-202-371-8300.

The John Hancock Affiliated Companies

John Hancock is a subsidiary of Manulife Financial Corporation. The following affiliated companies provide this notice and/or may provide you with information about John Hancock's products and services:

- John Hancock Life Insurance Company (U.S.A.)
- John Hancock Life & Health Insurance Company
- John Hancock Life Insurance Company of New York
- John Hancock Signature Services, Inc.
- John Hancock Personal Financial Services, LLC.
- John Hancock Retirement Plan Services, LLC.
- John Hancock Trust Company, LLC.
- John Hancock Investment Management, LLC.
- John Hancock Investment Management Distributors, LLC.
- John Hancock Variable Trust Advisers, LLC.
- Hancock Capital Investment Management, LLC.
- John Hancock Distributors, LLC.

Service Office:
Life New Business
John Hancock
410 University Ave, Suite 55765
Westwood, MA 02090

Life Insurance Illustration Certification

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 Policy Owner(s).
This certification must be submitted with the Application for Individual Life Insurance if a signed illustration is not submitted.

SECTION A: Proposed Insured(s)

LIFE ONE				LIFE TWO			
1. Name	FIRST	MIDDLE	LAST	2. Name	FIRST	MIDDLE	LAST

SECTION B: Policy Owner(s) Information – Complete information only if Policy Owner(s) is other than Proposed Insured.

3. Name of Policy Owner(s)

SECTION C: Policy Owner(s) Acknowledgement

I/We acknowledge that this Certification is being submitted with the Application for Individual Life Insurance for the reason set forth below and I/we understand that if a policy is issued, an illustration conforming to the policy as issued will be provided to me/us no later than at the time the policy is delivered.

☐ No illustration was presented to me/us in connection with the Application for Individual Life Insurance.

☐ An illustration was presented to me/us but it does not conform to the policy applied for on the Application for Individual Life Insurance.

☐ A computer screen illustration based on the following personal and policy information was displayed but a hard copy was not furnished to me/us.

	INSURED ONE	INSURED TWO
Gender	☐ M ☐ F	☐ M ☐ F
Age		
Rate Class		

POLICY TYPE
Product Name
Initial Death Benefit $
Rider(s)
Dividend Option (if applicable)
Interest Rates Illustrated (if applicable) a) Guaranteed % b) Non - Guaranteed %
Number of Years Illustrated
Illustrated Premium Amount $ for years

Vitality Benefit: If the policy applied for includes a Vitality benefit, I/we further understand and agree that if my application is approved, the cost of my policy will vary each year based on my participation in the John Hancock Vitality program, and my agent/registered representative is able to provide me with further details about how the costs may vary.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____ **X** _____
SIGNATURE OF POLICY OWNER SIGNATURE OF POLICY OWNER

SECTION D: Agent/Registered Representative Certification

I certify that no illustration conforming to the policy applied for was provided to the Policy Owner(s) for the reason checked off above. If I displayed a computer screen illustration for the above referenced Policy Owner(s), I certify that such illustration complied with state requirements, was based on the information as stated above, and no hard copy was furnished. I further certify that if a policy is issued, I will deliver an illustration conforming to the policy as issued and I will obtain a signature on such illustration no later than the time the policy is delivered.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____ **X** _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE NAME OF AGENT/REGISTERED REPRESENTATIVE (PLEASE PRINT)

Company Copy – Please provide Policy Owner(s) with a copy.

Authorization for Release of Information

For the purpose of obtaining the insurance that I have requested, I hereby authorize International Brokerage Agencies, Inc. and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other information under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") concerning to me to my Representative and its staff, affiliated companies an/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc.. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

PROPOSED INSURED'S NAME

PROPOSED INSURED'S SIGNATURE

SIGNED AND DATED ON AT (CITY, STATE, ZIP CODE)

AGENT/WITNESS