



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
%	<input type="checkbox"/> Yes			

b.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
%	<input type="checkbox"/> Yes			

c.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
%	<input type="checkbox"/> 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

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	
						<input type="checkbox"/> Male <input type="checkbox"/> Female	
3. Date of Birth		4. Place of Birth			STATE/COUNTRY		5. Social Security Number
MONTH	DAY	YEAR					
6. Driver's License Number/State		7. Citizenship					
		<input type="checkbox"/> US <input type="checkbox"/> Non US - Country of Citizenship _____ Type of Green Card/VISA _____					
8. Primary Residence		STREET ADDRESS		CITY	STATE	ZIP CODE	
9. Telephone Numbers		10. Email Address					
PERSONAL	BUSINESS	<input type="checkbox"/> Your email is required so we may communicate with you about your policy online					
11. Occupation							
<input type="checkbox"/> Job/Duties _____ Employed by _____ <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other _____							
12. Are you currently a member of the armed forces, including the reserves?							
<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Yes, complete <i>Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109</i>							
13. Gross Annual Household Income				14. Household Net Worth			
Salary \$ _____		Other \$ _____		\$ _____			
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?							
<input type="checkbox"/> Yes <input type="checkbox"/> No - If Yes, provide details _____							

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

Policy Split Option Rider

Healthy Engagement (Vitality PLUS) Rider

Return of Premium Rider (Death Benefit Option 1 only)

Disability Payment of Specified Premium Rider

Percentage of premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %

Monthly Specified Amount \$ _____

Estate Preservation Rider

Preliminary Funding Account

Overloan Protection Rider

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				b. Date of Birth		
FIRST	MIDDLE	LAST		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 Vlicated 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	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		\$

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 (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 <input type="checkbox"/> Recreational/Social <input type="checkbox"/> Medicinal – Provide Prescription Card ID _____		Date Last Used MONTH YEAR _ _ _ _
FREQUENCY _____ times per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year	DELIVERY METHOD <input type="checkbox"/> Ingested <input type="checkbox"/> Vaporized <input type="checkbox"/> Inhaled	
<input type="checkbox"/> 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
	<input type="checkbox"/> Daily <input type="checkbox"/> 1-3 x/week <input type="checkbox"/> 4-6 x/week	_____ hours _____ minutes
	<input type="checkbox"/> Daily <input type="checkbox"/> 1-3 x/week <input type="checkbox"/> 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:
 - questions 49, 50 and 51 are answered "No"
 - the Proposed Insured is age 20 to 70
 - 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*.

49. Within the last 24 months, has the Proposed Insured under this application:	PROPOSED INSURED
a. consulted a member of the medical profession for, been diagnosed with or been treated for any heart problem, stroke or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been declined for life insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
51. Does the Proposed Insured reside outside the United States more than 6 months per year?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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 known 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
%	<input type="checkbox"/> Yes			

b.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
%	<input type="checkbox"/> Yes			

c.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM		AGENT CODE
% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
%	<input type="checkbox"/> 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



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



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

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)

PROPOSED INSURED (LIFE TWO)

1. Name FIRST MIDDLE LAST

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



Life Insurance Buyer's Guide



Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

This guide does not endorse any company or policy.

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Important Things to Consider



1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.

2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?

3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.

4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.

5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly**.

6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.

7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance also can be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?



- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up **cash values** and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.



What is the Right Kind of Life Insurance?

Life Insurance Buyer's Guide

You may be able to trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

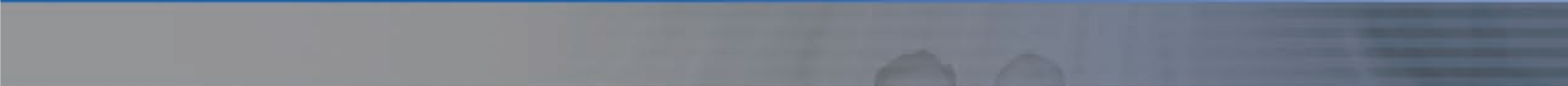
After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?



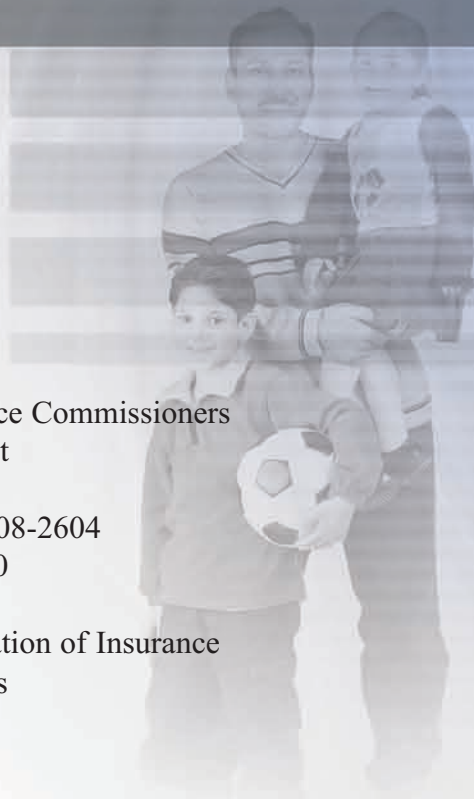
Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



National Association of Insurance Commissioners
2301 McGee St
Suite 800
Kansas City, MO 64108-2604
(816) 842-3600

© 1997, 2007 National Association of Insurance
Commissioners



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

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		

