John Hancock

Preparing for your life insurance Telephone Interview

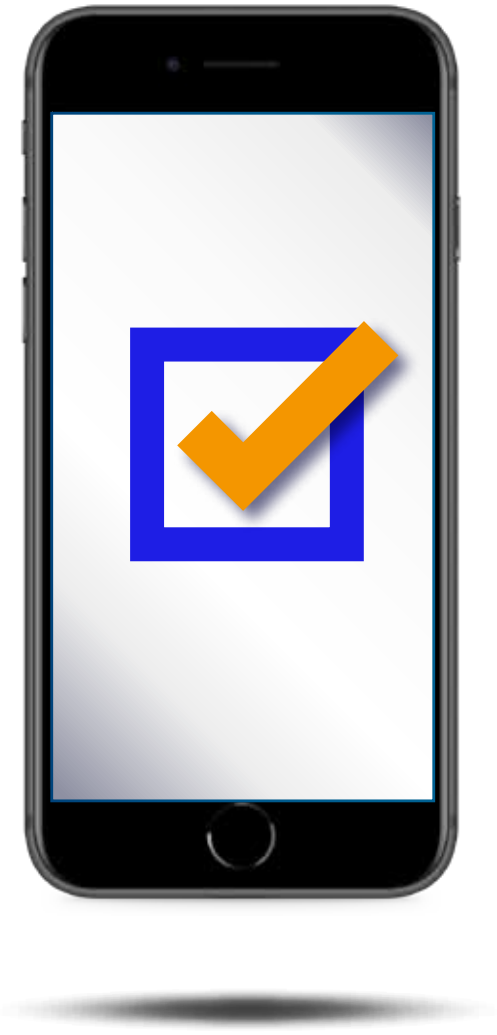
Thank you for considering John Hancock for your life insurance needs. Here is a brief description of what to expect during the telephone interview, and the next steps in the application process once the interview is complete.

Telephone Interview

Within 24 hours of your life insurance agent submitting the forms required to start the application process, a John Hancock representative will contact you (the proposed insured) to collect the information necessary to complete the life insurance application — or to set up a more convenient time. The telephone interview will take approximately 30-40 minutes. You will be asked to answer questions that encompass the following areas:

- Proof of identity and financial information
- Health and medical information
- Additional information on lifestyle, hobbies, etc.

While the majority of questions can be answered without preparation, there is some information you should have on hand for quick reference. The checklist on the following page can be used as a guide to help you prepare.



INSURANCE PRODUCTS:		
Not FDIC Insured	Not Bank Guaranteed	May Lose Value
Not a Deposit	Not Insured by Any Federal Government Agency	

Telephone Interview Checklist

Have the following information on hand for quick reference during your telephone interview.

Proof of Identity and Personal Information

- ☐ Social security number
- ☐ Driver's license number and state (and history of any moving violations or driving while impaired)
- ☐ Household net worth, including income
- ☐ Employment information, e.g., occupation, employer name
- ☐ Current life insurance coverage, including policy numbers, insurance company names, etc., if applicable

Health, Medical and Lifestyle Information

- ☐ Name, address, and phone number of current doctors, as well as any doctors visited in the last two years
- ☐ Names and dosages of current medications
- ☐ Medical history, including significant details such as diagnoses, surgeries, treatments, and pertinent close family health history, etc.
- ☐ Use of tobacco products, alcohol, and drugs
- ☐ Lifestyle questions (e.g., exercise habits, travel, and any high-risk sports such as sky diving, hang gliding, etc.)
- ☐ If you have applied for a rider that provides long-term care coverage, you may be asked questions pertaining to how you handle activities of daily living (e.g., personal care, meal preparation, etc.)

PLEASE NOTE:
It is important to answer all questions in the telephone interview truthfully and completely. John Hancock will obtain additional information, e.g., prescription histories, medical records, etc., to evaluate your application for insurance and identify any misrepresentation in the application. Any material omissions or misrepresentations may invalidate coverage and result in a denial of benefits or rescission of any policy issued on the basis of such application.

Review and Sign the Application

Within 24 hours of completing the telephone interview, you will receive an email with a secure link to review the completed application and apply an eSignature. (Please note that if the proposed insured is different from the policy owner, email addresses for both individuals must be provided, as signatures will be needed from both individuals.)

The Paramedical Exam

John Hancock will assess the application using the information gathered from the telephone interview and will determine if additional medical information, collected via a paramedical examination, is required. In these scenarios, John Hancock will set up the appointment at a convenient time for you. The paramedical examination can take place at your home or a nearby medical office, and will involve a licensed health professional collecting additional details to your health, including blood and urine samples, taking your blood pressure, and assessing your height and weight. Here are some tips to help you prepare for the paramedical exam if it is required:

The basics:

- Have your personal identification handy at the examination
- Get a good rest the night before your appointment
- Don't do any heavy exercise for 24 hours before the exam
- Wear short sleeves or sleeves that can be easily rolled up
- If you are a woman, mention to the examiner if you are menstruating at the time of the exam (because it can cause blood in the urine specimen)
- If you are taking prescription medications, continue to take them as prescribed
- If you are ill or under severe stress at the time of the exam, consider rescheduling for a future date when you've fully recovered

If you have hypertension:

- Avoid using alcohol, cigarettes, caffeine and other stimulants prior to your exam
- Ask your examiner to take your blood pressure after you have had an opportunity to relax; aim for three attempts taken 10 minutes apart

If You Have Diabetes:

- Schedule your paramedical exam for 2½ hours after a sugar- and sweets-free meal
- Empty your bladder immediately after the meal

If your policy is approved for issue based on John Hancock's review of the information collected during the telephone interview and paramedical exam (if applicable), and any other applicable underwriting requirements, **your life insurance agent will deliver a policy package to you.**

If you have questions, please contact your *Life Insurance Agent.*

John Hancock®

Insurance products are issued by: John Hancock Life Insurance Company (U.S.A.), Boston, MA 02210 (not licensed in New York) and John Hancock Life Insurance Company of New York, Valhalla, NY 10595.
MLINY060917045

John Hancock

Drop Ticket Submission Checklist

Available for all John Hancock Single Life Products

1. Instructions to the Agent or Financial Advisor

Based on the options selected in the forms tool, the Drop Ticket Package will be compiled for the appropriate state and product combination. When completing the forms in the Ticket Package, remember to complete all sections and obtain all signatures, to ensure that the Ticket is in good order.

2. Forms to be given to the Proposed Insured and/or Owner at time of sale

Required Forms:

☐ Preparing for Your Life Insurance Telephone Interview Flyer

☐ Notice of Disclosure (ICC16 NB6006/NB5006)

☐ Customer Privacy Notice

Only if Applicable

☐ State Specific Disclosures

☐ Copies of Replacement forms, if applicable

☐ Notice of Protected Health Information Privacy Practices

☐ Outlines of Coverage (Long-Term Care or Critical Illness Benefit Riders)

☐ Temporary Life Insurance Receipt and Agreement (ICC16 NB6004/NB5004)
If applying for TIA, the Telephone Interview must be completed 10 days after submission.

3. Forms to be submitted PRIOR to the Interview

☐ Drop Ticket Package

☐ State-appropriate Replacement Forms

☐ Indexed UL - Premium and Segment Proceeds Allocation Instructions (for IUL only)

☐ Variable Fund Allocation Form (for VUL only)

4. Forms to be submitted PRIOR to Issue, if applicable

3rd Party Ownership

☐ Trust Certification

☐ Third-Party Ownership Disclosure – Long-Term Care Riders

☐ Third-Party Ownership Disclosure – Critical Illness Benefit Rider Disclosure

☐ Financial Supplement for Business Insurance

Term and Term with Vitality:

☐ Financial Supplement for Personal Insurance *(based on Face Amount rather than Product Type)*

☐ Signed Illustration or Certification Receipt *(if applicable)*

Permanent Products:

☐ Third-Party Ownership Disclosure – Long-Term Care Riders

☐ Third-Party Ownership Disclosure – Critical Illness Benefit Rider Disclosure

☐ Application Supplement: Individual Insurance Critical Illness Benefit Rider

☐ Financial Supplement for Personal Insurance *(based on Face Amount rather than Product Type)*

☐ Signed Illustration or Certification Receipt *(if applicable)*

John Hancock

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

Drop Ticket

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

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Sex ☐ Male ☐ Female

3. Date of Birth MONTH DAY YEAR

4. Social Security Number

5. Email Address

6. Telephone Numbers PERSONAL BUSINESS CELL

7. Primary Address STREET CITY STATE ZIP CODE

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

9. Household Net Worth
$ _____

SECTION B: Policy Owner – Complete if Policy Owner is someone other than the Proposed Insured

10. 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 _____

11. Policy Owner Relationship
☐ Spouse ☐ Child ☐ Trust
☐ Other _____

12. Name or Entity/Trust Name FIRST MIDDLE LAST

13. Date of Birth or Trust Date (if applicable)
☐ DOB MONTH DAY YEAR
☐ Trust Date MONTH DAY YEAR

14. Social Security OR Tax ID Number
☐ SSN
☐ Tax ID

15. Telephone Number

16. Email Address

17. Address STREET CITY STATE ZIP CODE

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

19. Is the Policy Owner a Non US Person or a Non Resident Alien? ☐ Yes ☐ No *If Yes, Complete IRS Form W-8BEN for individuals*

20. Lapse Notification Handling - Secondary Addressee
Name FIRST MIDDLE LAST
Date of Birth MONTH DAY YEAR
Address STREET CITY STATE ZIP CODE

SECTION C: Beneficiary Information

21. Name or Entity/Trust Name FIRST MIDDLE LAST

22. Percentage _____ %

23. Relationship to Proposed Insured
☐ Spouse ☐ Child ☐ Trust ☐ Business Partner ☐ Employer ☐ Other _____

24. Name or Entity/Trust Name FIRST MIDDLE LAST

25. Percentage _____ %

26. Relationship to Proposed Insured
☐ Spouse ☐ Child ☐ Trust ☐ Business Partner ☐ Employer ☐ Other _____

SECTION D: Coverage Details

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

☐ Universal Life ❗ *If applying for Indexed UL, complete Premium Allocation Instructions NB5176*

☐ Variable Universal Life ❗ *Complete Fund Allocation NB5136*

a. ☐ Base Face Amount $ _____

b. ☐ Supplemental Face Amount $ _____

☐ 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 ☐ Choose a Monthly Acceleration Percentage ☐ 1% ☐ 2% ☐ 4%

☐ 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

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 ☐ Unemployment Protection Rider ☐ Other _____

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

☐ Healthy Engagement (Vitality PLUS) Rider (Protection Term only) ❗ *When you select this rider, the Vitality PLUS Program will be included with your 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.*

☐ John Hancock Aspire – a solution for people living with diabetes

27. State of Solicitation _____

28. Purpose of Insurance ☐ Income Replacement ☐ Estate Planning ☐ Other - give details _____
☐ Business Insurance ❗ *Complete Financial Supplement for Business Insurance NB5124*

29. Premium Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Pre-Authorized Payment Plan only)

30. Premium 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* ☐ Other - give details _____

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 _____

32. 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 _____

SECTION E: Existing Insurance and Replacement Information

33. Have you been offered money or other consideration by any person or entity in connection with this application?
☐ Yes ☐ No - If Yes, give details _____

34. a. Does the Policy Owner have any existing life insurance and/or annuities with this or any other company?
☐ Yes ☐ No ❗ *If Yes, complete state appropriate replacement forms*

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 ☐ No ❗ *If Yes, complete state appropriate replacement forms*

35. 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 35b*

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	
	☐	☐		☐	☐	☐	☐	☐	☐	☐		$
	☐	☐		☐	☐	☐	☐	☐	☐	☐		$

SECTION F: TIA Coverage

36. Would you like to be considered for TIA coverage with your application? ☐ Yes ☐ No

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

Authorization to Obtain Information

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

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

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

SECTION B: Authorization to Obtain Information

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, or the MIB, Inc. to disclose health information about me or any minor child/children who are 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 communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law. This authorization excludes the release of any information relating to the performance or results of prior HIV or HIV-related tests, except such tests that were conducted in connection with obtaining insurance. Nothing in this caveat will prohibit the release of records that reveal that the Proposed Insured has AIDS.
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.

SECTION C: Signatures

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

SIGNED AT CITY STATE THIS DAY OF YEAR

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

X _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

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 Medical Information Bureau, 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 and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes; or
3. 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

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.**
     - **Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance NB5019.**

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

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

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	
%	☐ 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: Acknowledgement, Certification and Signature

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

I hereby acknowledge and agree that I have complied with my responsibilities under John Hancock's Agent Code of Conduct and Producer Terms & Conditions, including but not limited to the following:

- **My product and service recommendations were based on a thorough, documented analysis of my client's needs and financial objectives. I have retained all documentation and will produce it upon request.**
- **Each of my product and service recommendations was designed to satisfy those needs and objectives in a way that is appropriate and suitable for the client.**
- **If this is a Replacement transaction, I have determined, as supported by a documented analysis of my client's needs and financial objectives, that the transaction is demonstratively in the best interest of the client and in compliance with all applicable state and Company requirements, that I have disclosed all the advantages and disadvantages of any replacement, and the client fully understands the financial consequences of the Replacement Transaction.**

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.

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

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

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

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.

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 is required by law. It describes our privacy policy and how we handle our customers' and former customers' personal information.

- For information on how we use data collected from visitors of John Hancock websites, social media sites, and mobile applications, please refer to the John Hancock Online Privacy Policy.
- If you have a policy that is covered by the Health Insurance Portability and Accountability Act, please refer to our HIPAA Notice of Protected Health Information Privacy Practices.
- If you live in Europe and the United Kingdom, please refer to our privacy notice for European residents for information on your rights under the General Data Protection Regulation.

These notices, and information about the rights of consumers under California law, such as the California Consumer Privacy Act, 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 financial products and services. It also helps us to confirm your identity, detect and prevent fraud, manage our business, and fulfill legal and regulatory requirements. The type of information we collect depends on the products or services you applied for or have with us.

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

- personal data, such as name, address, email address, telephone number, date of birth, Social Security number, sex, citizenship status, race/ethnicity, occupation, and employment details;
- 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;
- profile data reflecting a person's preferences, interests, hobbies, characteristics, tendencies, behaviors, or attitudes; and
- interaction data collected when you visit or use our websites, mobile applications, and social media sites, or when you call or chat online with our customer service teams.

Our sources include your insurance agent, broker, registered representative, or financial advisor and their respective firms, your employer or Plan Sponsor, consumer reporting agencies, government agencies, medical providers, data service providers, social media services, 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, evaluate your application, 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;
- your financial advisor, broker, representative, or firm in order for them to process and service your application, policy, or account;
- consultants and third parties performing administrative, marketing, and technology 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 sell, use, or disclose your information for their own marketing purposes;
- reinsurance companies;
- auditors and government agencies to conduct routine or required activities such as audits and tax reporting;
- attorneys and other legal professionals in response to subpoenas and court orders, or to comply with legal requests made by law enforcement and regulatory authorities;
- other financial institutions with whom we may jointly market products or services that may be of interest to you, if permitted in your state; and
- other third parties at your request, with your consent or your written authorization.

We do not sell your personal information. We do not share it with any unaffiliated company for the purpose of that company marketing its own products or services 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 products or services. You have the right to opt out of that information sharing.

If you have coverage under an employer-sponsored retirement plan, group pension contract, group annuity contract, or group insurance policy, or if you are a client of John Hancock Investment Management LLC, 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.

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 the personal information we have collected 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, long-term care insurance, annuity, mutual fund, etc.); and
- policy contract or account number.

If you believe that information we have about you is outdated or incorrect, you may write us and request it be amended. 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
Life Post Issue—Customer Service Center
PO Box 55979, Boston MA 02205-5979

800-732-5543
www.johnhancock.com

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

U.S. Compliance Department
197 Clarendon Street, C-5, Boston, MA 02116

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

John Hancock

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.

John Hancock

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

Important Notice Regarding Replacement of Life Insurance or Annuities

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

REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

SECTION A: List of Policies or Contracts to be Replaced

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. 1035 Exchange? ☐ Yes ☐ No	**d.** 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. 1035 Exchange? ☐ Yes ☐ No	**d.** 1035 Exchange? ☐ Yes ☐ No

SECTION B: Signatures

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

John Hancock

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

Request for Pre-Authorized Payment Plan

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

1. Policy Number (if available) _____

Proposed Insured One

2. a) Name First Middle Last

Proposed Insured Two

b) Name First Middle Last

Pre-Authorized Payment Plan Options

3. a) ☐ All Premium Payments (including initial premium) ☐ Subsequent Premiums (Initial by check)
☐ All Premium Payments (including TIA) **Please note, John Hancock will not draft until the policy is issued.*
b) ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Single Planned Premium
c) Amount $ _____ Important Note: Amount may vary for Healthy Engagement Term and for Universal Life policies with LifeTrack billing. See sections 5e and 5f below.

Pre-Authorized Payment Banking Information (a void check can be provided in place of account/routing information)

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

b) Relationship to Policyowner/Relationship to Life Insured

c) Name of Financial Institution

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

e) Type of Account ☐ Saving ☐ Checking Account Number _____ Routing Number _____

Signature(s) - If the Bank Account Owner is a company or trust, an authorized officer must sign stating title and affixing seal or stamp. (continued on page 2)

I (We) hereby authorize and request The Company to electronically debit via ACH my (our) account to pay premiums on this policy or any policies subsequently designated (and, if necessary, electronically credit my (our) account to correct erroneous debits or to make premium refunds).

5. I (We) understand and agree that:

a) The initial premium payment, if paid through the Pre-Authorized Payment Plan, will be withdrawn at policy issue.

b) Additional future withdrawals shall be drawn to pay premiums falling due on the designated policies.

c) For a new policy, depending on the selected frequency and the effective date, the required withdrawal amount may differ from the amount indicated above.

d) To the extent a Temporary Life Insurance Agreement was put in effect based on receipt of this form, I authorize The Company to deduct an amount equal to one-twelfth of the annual premium for the base plan and any supplemental benefits requested in the application from any death benefit that may become payable under such Temporary Life Insurance Agreement.

e) For Universal Life policies that elect LifeTrack billing, I authorize The Company to withdraw an amount equal to the LifeTrack premium amount then falling due from my (our) account. I understand that for LifeTrack, my (our) billed premium will adjust automatically each year to take into account actual policy experience. The LifeTrack premium calculation is based on my (our) current LifeTrack policy objectives, actual Policy Value, timing and the amount of premiums paid, and updated assumptions for the policy's nonguaranteed elements, such as the interest rate, and charges. If the policy is issued with the Healthy Engagement Rider, then the Life Insured's Status will also be used in the LifeTrack premium calculation. The Company will provide written notice if there is a change in the withdrawal amount required to pay the LifeTrack premium amount then falling due at least twenty one (21) days prior to the date of withdrawal.

f) For Healthy Engagement Term policies, I authorize the Company to withdraw an amount equal to the premium based on the Status achieved by the Life Insured on the Annual Processing Date, as described in the policy, from my (our) account. The Company will provide written notice if there is a change in the withdrawal amount required to pay the premium due at least twenty-one (21) days prior to the date of withdrawal.

Continue to page 2 to complete Signature(s).

Signature(s) - If the Bank Account Owner is a company or trust, an authorized officer must sign stating title and affixing seal or stamp. (continued from page 1)

g) For policies that elect traditional billing, The Company will not provide notices of withdrawals to pay planned premiums falling due on such policies while the Pre-Authorized Payment Plan is in effect.
h) The Pre-Authorized Payment Plan may be terminated by me (us) by written notice to The Company by the Policyowner. Such notice to be provided 14 days prior to the next withdrawal date. If the Pre-Authorized Plan is terminated, planned premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
i) Any changes to existing payment or banking information must be submitted to The Company at least two weeks prior to the next scheduled withdrawal date.
j) The origination of ACH transactions to my (our) account must comply with all applicable law, and I (we) agree that the ACH transactions authorized by me (us) comply with all applicable law.
k) If the payment dates fall on a weekend or holiday, I (we) understand that the payments may be executed on the next business day. I (We) understand that these are electronic transactions and funds may be withdrawn from my (our) account as soon as the above noted payment dates.
l) I (We) agree not to dispute these pre-authorized, scheduled payments with my (our) banks as long as the transaction corresponds to the terms indicated in this authorization form.
m) By signing this form I (we) confirm the accuracy and validity of the banking information provided for the requested automated withdrawal process.

Signed at City/State	Date
Name of Bank Account Owner - Please Print	Signature of Bank Account Owner
	x