John Hancock

Mailing Address
Attn: Life New Business
John Hancock Insurance Services
PO Box 55765
Boston, MA 02205-5765

Overnight Courier
Attn: Life New Business
John Hancock Insurance Services
410 University Ave, Suite 55765
Westwood, MA 02090

New Business Transmittal

Transmittal Date

SECTION A: Firm Information

1. Name of Firm

☐ Formal
☐ Informal Query (IQT)

SECTION B: New Business Firm Contact

2. Name of New Business Firm Contact

3. Address STREET ADDRESS CITY STATE ZIP CODE

4. Phone Number	5. Fax Number	6. Email Address
7. Is this a Wholesaling case? ☐ Yes ☐ No	8. Name of Broker Dealer	

SECTION C: Point of Sale Contact

9. Name of Point of Sale Contact

10. Address STREET ADDRESS CITY STATE ZIP CODE

11. Phone Number	12. Fax Number	13. Email Address

SECTION D: Producer Information

14. Name of Producer FIRST MIDDLE LAST	15. Phone Number	16. Fax Number

17. Social Security Number	18. John Hancock Producer Code	19. Registered Representative Central Registration Depository Number (CRD)	20. National Producer Number (NPN)

IMPORTANT: To avoid delays in processing this application, please ensure that the producer is properly LICENSED with the applicable John Hancock company in the state where this application is being solicited.

SECTION E: Proposed Insured Information

21. Name of Proposed Insured - Life One		22. Name of Proposed Insured - Life Two	
23. Phone Number	24. Best Time to Call	25. Phone Number	26. Best Time to Call

SECTION F: Comments/Special Handling Instructions

John Hancock

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

Application For Individual Life Insurance

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

If applying for Survivorship Coverage, please also complete *Survivorship Supplement for Second Life NB5211.*
Print and use black ink. Any changes must be initialed by the Proposed Insured and the Policy Owner.

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

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

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Sex ☐ Male ☐ Female

3. Date of Birth MONTH DAY YEAR

4. Place of Birth STATE/COUNTRY

5. Social Security Number

6. Driver's License Number/State

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

8. Primary Residence STREET ADDRESS CITY STATE ZIP CODE

9. Telephone Numbers PERSONAL BUSINESS

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

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

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

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

14. Household Net Worth
$ _____

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

SECTION B: Policy Owner

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

16. a. Policy Owner Type

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

If Trust Owner, complete the Trust Certification PS5101

If Partnership Owner, complete the Partnership Statement PS7800US

☐ Other _____

b. Policy Owner Relationship

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner ☐ Employer ☐ Other _____

c. Name or Entity/Trust Name FIRST MIDDLE LAST

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

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Address STREET ADDRESS CITY STATE ZIP CODE

g. Telephone Number

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

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

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

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

SECTION C: Beneficiary Information

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

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

b. Percentage _____ %

c. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner ☐ Employer ☐ Other _____

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

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

e. Social Security OR Tax ID

☐ SSN

☐ Tax ID

f. Telephone Number

g. Email Address

h. Address STREET ADDRESS CITY STATE ZIP CODE

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

b. Percentage _____ %

c.

☐ Primary ☐ Secondary

d. Relationship to Proposed Insured

☐ Spouse ☐ Child ☐ Trust ☐ Business Partner ☐ Employer ☐ Other _____

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

☐ DOB MONTH DAY YEAR

☐ Trust Date MONTH DAY YEAR

f. Social Security OR Tax ID

☐ SSN

☐ Tax ID

g. Telephone Number

h. Email Address

i. Address STREET ADDRESS CITY STATE ZIP CODE

SECTION D: Coverage Details

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

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

22. Flexible Premium Products

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

☐ Variable Universal Life ❗ *Complete Fund Allocation NB5136*

a. ☐ Single Life

☐ Survivorship ❗ *Complete Survivorship Supplement for Second Life NB5211*

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) NB5018*

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

☐ Cash Value Enhancement Rider

☐ Healthy Engagement (Vitality PLUS) Rider

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

☐ Estate Preservation Rider

☐ Overloan Protection Rider

☐ Policy Split Option Rider

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

☐ Preliminary Funding Account

☐ Other _____

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

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

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 NB5124*

☐ Other - give details _____

28. Lapse Notification Handling

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

a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

c. Address STREET ADDRESS CITY STATE ZIP CODE

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

☐ Yes ☐ No - If Yes, give details _____

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

☐ Yes ☐ No - If Yes, give details _____

30. Premium (Payment) Source

☐ Income

☐ Liquidated Assets - give details _____

☐ Proceeds from Sold or Viaticated policy - give details _____

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

☐ Other - give details _____

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

SECTION E: Purpose And Funding Information (continued)

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

31. a. Name all lenders involved

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

Amount $ _____ Type of collateral _____

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

☐ Yes ☐ No - If Yes, give details _____

SECTION F: Existing, Replacement, And Pending Insurance Information

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

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

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

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

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

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

INSURANCE COMPANY	FACE AMOUNT INCLUDING RIDERS
	$
	$

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

SECTION G: Personal Information

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

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

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

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

b. Address STREET ADDRESS CITY STATE ZIP CODE

c. Telephone Number

d. Date of last visit MONTH DAY YEAR

e. Reason for last visit, outcome and treatment prescribed

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

b. Name of Health Insurance Provider (if applicable)

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

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

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

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

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

☐ I have never used nicotine/tobacco products

SECTION G: Personal Information *continues on next page*

SECTION G: Personal Information (continued)

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

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

PURPOSE

☐ Recreational/Social

☐ Medicinal – Provide Prescription Card ID _____

Date Last Used

MONTH YEAR

FREQUENCY

_____ times per ☐ Day ☐ Month ☐ Year

DELIVERY METHOD

☐ Ingested ☐ Vaporized ☐ Inhaled

☐ I have not used marijuana in the past 5 years

SECTION H: Lifestyle Information

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

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

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

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

☐ I do not participate in an exercise routine

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

☐ Yes ☐ No

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

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

☐ Yes ☐ No

If Yes, provide details _____

SECTION H: Lifestyle Information *continues on next page*

SECTION H: Lifestyle Information (continued)

43. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?
☐ Yes ☐ No
If Yes, give details of location (city/country), purpose, frequency and duration _____

44. Have you ever flown or intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes?
☐ Yes ☐ No ❗ *If Yes, complete Aviation Questionnaire NB5009*

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 NB5010*

46. Please indicate which of the following apply to your driving history:
☐ Cited for 1 or more moving violations in the past 2 years ☐ Cited for 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, imprisoned 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 NB5004 may only be issued if:
  1. questions 49, 50 and 51 are answered "No"
  2. the Proposed Insured is age 20 to 70
  3. the amount applied for under this application is not greater than $10,000,000 (single life) or $15,000,000 (survivorship)

  Note: Temporary Life Insurance questions must be answered by both insureds if Survivorship coverage is being applied for. See *Survivorship Supplement for Second Life NB5211*.

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

SECTION K: Additional Information

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

SECTION	QUESTION NUMBER	DETAILS

SECTION L: Special Instructions

Read the following carefully and sign next page

DECLARATIONS

The Proposed Insured (or Parent or Guardian) and Policy Owner declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of their knowledge and belief. All such statements and answers are representations, not warranties.

In addition, I/we understand and agree that:

1. **Policy Application:** The statements and answers in this application, which include any supplemental form relating to health, aviation practices or lifestyle of the Proposed Insured, will become part of the insurance policy issued as a result of this application. No information about me will be considered to have been given to The Company unless it is stated in the application or any form that is made part hereof.
2. **Policy Effective Date:**
   - **a)** Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered to the Policy Owner, provided that the Proposed Insured is still living and to the best of the knowledge and belief of the Policy Owner and Proposed Insured 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 NB5004.
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, or the MIB, Inc. to disclose health information about me/us 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 a Proposed Insured(s) 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.

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

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.

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

Instructions for Application For Individual Life Insurance

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

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

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

1. Do You Have the Correct Form?

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

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

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

2. Survivorship Coverage

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

3. Business Coverage

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

4. Request for Taxpayer Identification Number and Certification

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

5. Buyer's Guide

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

6. Replacements

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

7. Special Rider Instructions

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

Healthy Engagement (Vitality PLUS) Rider

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

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

Long-Term Care Rider

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

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

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

Provide the Proposed Insured with:

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

Critical Illness Benefit Rider

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

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

Critical Illness Benefit Rider (continued)

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

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

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

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

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

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

9. Employer/Corporate Owned Policies

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

10. Military Personnel Policies

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

11. Coverage Details

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

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

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

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

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

Notice of Disclosure of Information

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

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: Information Exchange

This brief description of our underwriting process is designed to help you understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others, and your right to learn the nature and substance of that information upon written request.

The purpose of the underwriting process is to make sure that you qualify for life insurance and if so, to establish the proper premium charge for that insurance. The information necessary to evaluate your application is dependent upon your age, the amount of insurance you are applying for, your medical history, your occupation, your avocations and other personal information. Your answers on the application are the principal source of information; however, additional sources of information may be required.

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

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Information for consumers about MIB may be obtained on its website at **www.mib.com**.

SECTION C: Investigative Consumer Report Notice

As part of our normal procedure, an investigative consumer report may be prepared concerning your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

On request to the Chief Underwriter, at the above Service Office address, we will disclose to you whether or not an investigative consumer report was done, the nature and scope of the report, a summary of consumer rights and the name and address of the consumer reporting firm from whom you may request a copy of the report.

SECTION D: Insurance Information Practices

The personal information we obtain about you is confidential and we will not disclose it to other parties without your written authorization except as permitted or required by law. You have the right to access the personal information about you that appears in our files, including any medical record information disclosed within three years of your request, unless that information relates to a claim or a civil or criminal proceeding.

However, we will normally give medical record information only to a licensed physician of your choice. You also have the right to seek correction of information about you that you believe to be inaccurate or incomplete. We will provide you with a more detailed explanation of our information practices and access and correction procedures if you send us a written request. You may do so by writing to the Chief Underwriter at the above Service Office address.

Please provide each Proposed Insured with a copy.

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

Life Insurance Illustration Certification

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

Print and use black ink. Any changes must be initialed by the Policy Owner(s).
This certification must be submitted with the Application for Individual Life Insurance if a signed illustration is not submitted.

SECTION A: Proposed Insured(s)

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

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

3. Name of Policy Owner(s)

SECTION C: Policy Owner(s) Acknowledgement

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

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

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

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

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

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

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

SIGNED AT CITY STATE THIS DAY OF YEAR

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

SECTION D: Agent/Registered Representative Certification

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

SIGNED AT CITY STATE THIS DAY OF YEAR

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

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

Summary and Disclosure Statement for Accelerated Benefit

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

(hereinafter referred to as The Company)

Name of Proposed Life Insured	Name of Owner (If other than the Proposed Life Insured)	Policy Number

This disclosure statement provides a brief description of the benefit available under the Accelerated Benefit Rider for an acceleration of your life insurance benefits. The full details of the benefit are included in the actual rider.

Description of the Accelerated Benefit

The Accelerated Benefit Rider provides for the payment of a portion of the death benefit under a life insurance policy to the policy owner if the life insured is terminally ill and has a life expectancy of one year or less. The accelerated benefit can only be paid once under the rider. There is no premium charged for the rider.

Conditions or Occurrences Triggering Payment of the Accelerated Benefit

Payment of the accelerated benefit is triggered by our receipt of written evidence satisfactory to us that the life insured is terminally ill and has a life expectancy of one year or less. Part of the evidence must be a written statement from a licensed medical doctor stating the prognosis for the illness.

Effect on Policy if an Accelerated Benefit is Paid

1. Death Benefit: The death benefit of your policy will be reduced by the accelerated benefit paid, plus one year's interest, plus any administrative expense charge.
2. Cash Value: The cash value of your policy will be reduced. The reduced cash value will be equal to the result of the original cash value multiplied by the death benefit remaining after the accelerated benefit is paid, divided by the death benefit before the accelerated benefit is paid.
3. Policy Debt: If your policy has a loan against it, the policy loan will be reduced by the same proportion as the cash value.
4. Premium: There is no change to the premium payable for your policy.

Receipt of the Accelerated Benefit is intended to qualify for favorable tax treatment under section 101(g)(1)(A) of the Internal Revenue Code of 1986 as amended by Public Law 104-191. However, receipt of the benefit may affect eligibility for Medicaid and certain other public assistance programs. You should consult with your personal tax advisor and social service agencies before you decide to receive the benefit.

I/We acknowledge that I/we have received and read this Summary and Disclosure Statement for the Accelerated Benefit.

Signatures

Signed at	This	Day of	Year

Signature of Agent / Registered Representative
x

Signature of Proposed Life Insured
x

Signature of Owner (If other than Proposed Life Insured)
x

John Hancock

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

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) 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. confidential information related to communicable diseases and mental illness (excluding psychotherapy notes); or
3. 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 a Proposed Insured(s) has AIDS.

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 _____ **X** _____
SIGNATURE OF PROPOSED INSURED PRINT NAME

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

PART II Medical Supplement

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

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

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

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

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

SECTION A: General Information

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

1. Name FIRST MIDDLE LAST

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

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

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

SECTION A: General Information (continued)

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

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

7. Have you had any weight loss or gain of 10 lbs. or more in the past 12 months for reasons other than intentional diet or exercise?

☐ Yes - specify lbs.: _____ Lost _____ Gained

☐ No

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

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

SECTION B: Medications

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

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

PRESCRIPTION NAME	HEALTH REASONS FOR WHICH THIS MEDICATION IS TAKEN

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

SECTION C: Medical Questions

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

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

Check all that apply and provide complete details.

a.

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Cardiac Chest Pain
- ☐ Arrhythmia/Irregular Heart Beat
- ☐ Heart Murmur/Valvular Heart Disease
- ☐ Heart Failure
- ☐ Peripheral Vascular Disease
- ☐ Stroke/Transient Ischemic Attack (TIA)
- ☐ Diseases of the Heart or Blood Vessels *(e.g. Aneurysm, Thrombosis, Carotid Artery, Cardiomyopathy, Pacemaker, Defibrillator)*
- ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL QUESTIONS

QUESTION NUMBER: _____

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

QUESTION 11 *continues on next page*

b.

- ☐ Diabetes
- ☐ High Blood Sugar/Glucose Intolerance/Pre-Diabetes
- ☐ Diseases of the Thyroid or Other Glands *(e.g. Hyper/Hypothyroid, Parathyroid, Pituitary, Adrenal)*
- ☐ None of these apply to me

c.

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

d.

- ☐ Anemia/Blood Disease *(e.g. Hemophilia, Polycythemia, Clotting Factor Deficiency, Hemochromatosis)*
- ☐ Autoimmune Disease *(e.g. Lupus, Scleroderma, Sjogren's)*
- ☐ None of these apply to me

e.

- ☐ Asthma
- ☐ Emphysema/COPD/Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Diseases of Respiratory/Lung *(e.g. Pulmonary Embolism, Cystic Fibrosis, Sarcoidosis)*
- ☐ None of these apply to me

f.

- ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Paralysis
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Cognitive Impairment/Memory Loss
- ☐ Alzheimer's Disease/Dementia
- ☐ Diseases of Nervous System or Neurological *(e.g. Neuropathy, Brain Injury, ALS, Restless Leg Syndrome)*
- ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL QUESTIONS

QUESTION NUMBER: ______________

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

QUESTION NUMBER: ______________

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

QUESTION NUMBER: ______________

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

QUESTION 11 *continues on next page*

SECTION C: Medical Questions (continued)

g.

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Diseases of Psychological or Mental Health *(e.g. PTSD, Schizophrenia, Eating Disorders)*
- ☐ None of these apply to me

h.

- ☐ Ulcers
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Crohn's/Ulcerative Colitis
- ☐ Barrett's Esophagus
- ☐ Diseases of the Liver, Gallbladder, Esophagus, Pancreas, Stomach, or Intestines *(e.g. Fatty Liver, Cholangitis, Pancreatitis, Gastric Bypass Surgery, Diverticulitis)*
- ☐ None of these apply to me

i.

- ☐ Rheumatoid/Psoriatic Arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Amputation
- ☐ Diseases of Bone, Joint, Muscle, or Connective Tissue *(e.g. Ankylosing Spondylitis, Chronic Fatigue/Pain, Joint Replacement)*
- ☐ None of these apply to me

j.

- ☐ Kidney Disease *(e.g. Polycystic Kidney, Nephritis, Kidney Failure)*
- ☐ Diseases of the Bladder or Urinary Tract *(e.g. Catheter, Neurogenic Bladder, Hematuria, Proteinuria)*
- ☐ Diseases of the Prostate *(e.g. Benign Prostatic Hypertrophy, Prostatitis, Prostate Nodule, elevated PSA)*
- ☐ Diseases of the Breast *(e.g. Fibrocystic Breast Disease, Breast Biopsy, Breast Lump/Cyst)*
- ☐ Diseases of the Reproductive Organs *(e.g. Abnormal Pap Test, Ovarian Cysts)*
- ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL QUESTIONS

QUESTION NUMBER: ____________

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

QUESTION NUMBER: ____________

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

QUESTION NUMBER: ____________

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

SECTION D: Medical Questions and Diagnostic Tests

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

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

☐ Yes ☐ No

If Yes, give details _____

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

☐ Yes ☐ No

If Yes, give details _____

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

☐ Yes ☐ No

If Yes, give details _____

15. Within the last 10 years, have you been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?

☐ Yes ☐ No

If Yes, give details _____

SECTION E: Personal Information

16. Describe your present alcohol consumption.

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

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

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

☐ I have not consumed alcohol in the past 10 years

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

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

SECTION F: Additional Medical Questions Details

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

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

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

SECTION G: Additional Information

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

QUESTION NUMBER	DETAILS

Read previous pages carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

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

2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, 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 a Proposed Insured(s) 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.

SIGNATURES

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

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

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

X _____

SIGNATURE OF EXAMINER (IF APPLICABLE)

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