John Hancock

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

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

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*)

☐ Healthy Engagement Rider (Vitality)

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

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

☐ Cash Value Enhancement Rider

☐ Disability Payment of Specified Premium Rider

☐ Disability Waiver of Monthly Deductions Rider

☐ Estate Preservation Rider

☐ Extended No-Lapse Guarantee Rider ❗ *Not all fund investment options are available with this rider*

☐ Overloan Protection Rider

☐ Policy Split Option Rider

☐ Return of Premium Rider *(Death Benefit Option 1 only)*

☐ Other _____

23. Term Products

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

☐ Healthy Engagement (Vitality) Term: ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ Other _____

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*

☐ Conversion Extension Rider (15 Year Term and 20 Year Term Only)

☐ Other _____

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. In the past 18 months, have you visited a dentist or hygienist for routine dental care?

☐ Yes ☐ No

39. 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)

40. 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

41. 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

42. 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 _____

43. 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)

44. 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 _____

45. 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*

46. 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*

47. 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

48. 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

49. 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 50, 51 and 52 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*.

50. Within the last 24 months, has the Proposed Insured under this application:	PROPOSED INSURED
a. consulted a member of the medical profession for, been diagnosed with or been treated for any heart problem, stroke or cancer?	☐ 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
51. 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
52. 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

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

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
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Agent Report

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

Print and use black ink. To be completed by the Agent/Registered Representative and submitted with Application for Life Insurance.

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. Is there or is the applicant considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in the application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Insured(s) as a result of the application? Examples of such an understanding or agreement include, but are not limited to, arrangements where the proposed Owner has or will have an option to sell to a third party the Owner's interest in the policy, or where a third party has or will have an option to buy the proposed Owner's interest in the policy.

☐ Yes ☐ No If Yes, give details

b. Will any policy issued on the life of the Proposed Insured(s) as a result of this application, replace a policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity? ☐ Yes ☐ No

c. Will the premiums, now or in the future, be funded by a loan or other means from someone other than the Proposed 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 are you, 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 or Long Term Care is being replaced, please give the Proposed Insured the **Notice for 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 – Select only one servicing agent

Where an entity is indicated in the credit line, also include the writing agent information in the chart below.

9. a.

NAME OF AGENT/ENTITY			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) _____

11. Enhanced Spread Compensation* ☐ Yes

*Available on Protection UL and Protection SUL policies only. If elected, this option would apply to all Agents on the policy. Please verify with your firm if this spread compensation option is available.

SECTION F: Certification and Signature

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

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

I certify that the state approved Buyer's Guide, Notice of Disclosure of Information and any other disclosure notice, statement or information required by state or federal law were given to the Owner at the time of the application and that no sales material other than that approved by The Company has been used.

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 Term Life Insurance - Single Life
John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

This kit is for John Hancock Single Life Term Insurance New Business only, excluding John Hancock New York

Applications for John Hancock New York, may be obtained from **www.jhsalesnet.com** or any other of our producer web sites.

1. Using the Application for Term Life Insurance - Single Life

This Application may only be used to apply for Single Life Term Insurance Products. To apply for Survivorship Term insurance or any other John Hancock Life Insurance Product (excluding SI or GI COLI products), please use Application for Life Insurance (NB5000) and appropriate supplementary forms.

2. 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 'State selection help' on the New Business Electronic Forms on **www.jhsalesnet.com**.

3. Request for Taxpayer Identification Number and Certification

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

4. 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'.

5. 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).

6. Military Personnel Policies

Military Personnel policies are policies where an active duty service member is the Proposed Life 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'.

7. Special Riders/Benefits Instructions

If the **Accelerated Death Benefit** (for terminal illness) is requested, provide the **Owner** with the **Disclosure Statement, NB1237**. This form is part of the Term Life Insurance kit.

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

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
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

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
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

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
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Temporary Life Insurance Receipt and Agreement

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

Print and use black ink.

SECTION A: Receipt

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

on PROPOSED INSURED (LIFE ONE)

1. Name FIRST MIDDLE LAST

PROPOSED INSURED (LIFE TWO)

2. Name FIRST MIDDLE LAST

3. Name of Owner

MONTH DAY YEAR

X _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

SECTION B: Temporary Life Insurance Agreement

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

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

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

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

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

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

Give this page to the Owner

Application Supplement

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

(hereinafter referred to as The Company)

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

- *This form is part of the Application for Life Insurance for the Proposed Life Insured.*
- *Print and use black ink. Any changes must be initialed by the Proposed Life Insured.*
- *Complete in all cases when electing the Acceleration of Life Insurance Death Benefits for Qualified Long-Term Care Services Rider.*

Proposed Life Insured

Name First Middle Last

Monthly Acceleration Percentage

1. Choose a Monthly Acceleration Percentage (select one only): ☐ 1% ☐ 2% ☐ 4%

Protection Against Unintended Termination

2. I understand that I have the right to designate up to three persons other than myself to receive Notice of Lapse/Termination of this insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a Rider Charge is due and unpaid.

☐ I elect. (complete information below) ☐ I DO NOT elect to designate a person(s) to receive such notice.

Name	Address - Street No. & Name, Apt No., City, State, Zip code
Name	Address - Street No. & Name, Apt No., City, State, Zip code
Name	Address - Street No. & Name, Apt No., City, State, Zip code

Insurance History

3. a) Are you covered by Medicaid? ☐ Yes ☐ No

b) Do you currently have or have you had during the last 12 months another accident and health or long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)? ☐ Yes ☐ No

c) Do you intend to replace any of your long-term care, medical or health coverage with the coverage applied for? ☐ Yes ☐ No

d) Do you have any other life insurance policies currently in force which provide similar long-term care coverage? ☐ Yes ☐ No

Details to "Yes" Answers.

Company	Policy/Certificate No.	Type and Amount of Benefits	Currently Inforce?		Is it Being Replaced?	
			Yes	No	Yes	No
			☐	☐	☐	☐
			☐	☐	☐	☐

Health Questions

4. a) Do you currently use mechanical devices, such as: a wheelchair, walker, crutches, hospital bed, dialysis machine, oxygen, or stairlift? ☐ Yes ☐ No

b) Do you currently need or receive help in doing any of the following: bathing, eating, dressing, toileting, transferring from bed to chair or maintaining continence? ☐ Yes ☐ No

c) Do you currently have, or have you ever had a diagnosis for or symptoms of:
   1. Alzheimer's disease, dementia, or organic brain syndrome? ☐ Yes ☐ No
   2. Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's Disease) or Parkinson's Disease? ☐ Yes ☐ No

d) Within the last 5 years, have you had symptoms of, received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions:
   1. transient ischemic attack, neurological disorders, depression, seizures, tremors, injury due to falls or imbalance, memory loss. ☐ Yes ☐ No
   2. bladder disorders, prostate disorders, disorders of the reproductive organs, liver disorders. ☐ Yes ☐ No
   3. osteoporosis, arthritis, fractures. ☐ Yes ☐ No

e) Within the last 5 years, have you ever been hospitalized or consulted or been treated by a member of the medical profession for any reason not previously stated? ☐ Yes ☐ No

f) Have you ever been confined to a nursing home or a custodial care facility? ☐ Yes ☐ No

g) Have you ever received home health care services? ☐ Yes ☐ No

Health Questions - continued

Details for Yes answers to questions 4. a) - g) inclusive.

Question No.	Date (mmm dd yyyy)	Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Doctor and Hospital

Agreement & Acknowledgment

I agree as follows: I am applying for an Acceleration of Life Insurance Death Benefits for Qualified Long-Term Care Services Rider that will become part of my Life Insurance Policy. I have reviewed the answers and statements in this application. To the best of my knowledge and belief, they are true, complete and have been correctly recorded. They are representations and not warranties. I understand that this application will form the basis of my coverage. Coverage will take effect on the Date of Issue. I also understand that the Rider will only cover myself and will not cover any other person. No other individual may subsequently assume the status of Covered Person under the Rider.

Acknowledgment: I have received the policy Outline of Coverage and a Replacement Notice (if replacement is involved).

Signed at City State This Day of Year

Signature of Agent/Registered Representative

Signature of Proposed Life Insured

x

x

Print name of Agent/Registered Representative

John Hancock

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

Agent Report

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

Print and use black ink. To be completed by the Agent/Registered Representative and submitted with Application for Life Insurance.

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. Is there or is the applicant considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in the application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Insured(s) as a result of the application? Examples of such an understanding or agreement include, but are not limited to, arrangements where the proposed Owner has or will have an option to sell to a third party the Owner's interest in the policy, or where a third party has or will have an option to buy the proposed Owner's interest in the policy.

☐ Yes ☐ No If Yes, give details

b. Will any policy issued on the life of the Proposed Insured(s) as a result of this application, replace a policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity? ☐ Yes ☐ No

c. Will the premiums, now or in the future, be funded by a loan or other means from someone other than the Proposed 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 are you, 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 or Long Term Care is being replaced, please give the Proposed Insured the **Notice for 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 – Select only one servicing agent

Where an entity is indicated in the credit line, also include the writing agent information in the chart below.

9. a.

NAME OF AGENT/ENTITY			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) _____

11. Enhanced Spread Compensation* ☐ Yes

*Available on Protection UL and Protection SUL policies only. If elected, this option would apply to all Agents on the policy. Please verify with your firm if this spread compensation option is available.

SECTION F: Certification and Signature

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

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

I certify that the state approved Buyer's Guide, Notice of Disclosure of Information and any other disclosure notice, statement or information required by state or federal law were given to the Owner at the time of the application and that no sales material other than that approved by The Company has been used.

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
27 Drydock Ave
Boston MA 02210-2377
Fax: 416-926-5599

Request for Pre-Authorized Payment Plan

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

(hereinafter referred to as The Company)

1. Policy Number (if available) _____

Proposed Insured One

2. a) Name First Middle Last

Proposed Insured Two

b) Name First Middle Last

Owner - if other than Proposed Insured(s)

3. Name First Middle Last

Pre-Authorized Payment Plan Options

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

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

c) Amount $ _____ Important Note: Amount may vary for Healthy Engagement Term and for Universal Life policies with LifeTrack billing. See sections 6d and 6e below.

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

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

b) Relationship to Policyowner/Relationship to Life Insured

c) Name of Financial Institution

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

e) Type of Account ☐ Saving ☐ Checking

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

6. 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) 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.

e) 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)

f) 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.
g) 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.
h) 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.
i) 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.
j) 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.
k) 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.
l) 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(s) - Please Print	Signature of Bank Account Owner(s) **x**
Name of Bank Account Owner(s) - Please Print	Signature of Bank Account Owner(s) **x**

John Hancock

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

Trust Certification

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

(hereinafter referred to as The Company)

Must be signed by Grantor(s) and Trustee(s)

Policy Number (if known) _____

PROPOSED INSURED(S) LIFE ONE

1. Name — First | Middle | Last

PROPOSED INSURED(S) LIFE TWO

2. Name — First | Middle | Last

3. Name of Trust (The Trust)

4. Name(s) of Grantor(s)

5. Name(s) of all Trustee(s)

6. a) Nature of the relationship between the Grantor(s) and the Trustee(s) | b) Duration of relationship

7. Who are the current beneficiaries of the Trust?

8. a) Effective Date of Trust — Month | Day | Year | b) Date Trust was signed/executed — Month | Day | Year | c) Situs of Trust: The signed/executed trust is subject to the laws of the State of

9. Address of Trust

10. Did you retain an attorney to prepare the trust document? ☐ Yes ☐ No (We will not contact the attorney without your written approval.)
If **'Yes'**, name and address of attorney. If **'No'**, name and address of provider.

Name of Attorney/Provider

Address of Attorney/Provider

CERTIFICATION

11. The Grantor(s) and Trustees(s) declare and represent to The Company that the answers provided in this Trust Certification are accurate and complete and also certify that:
   a) the Trust is: ☐ **Irrevocable and is in full force and in effect; -** *If Irrevocable is selected, is the Trust a Grantor Trust such that the Trust income tax events are attributable to the Grantor?* ☐ Yes ☐ No
   ☐ **Revocable and is in full force and in effect;**
   b) the Trustee(s) is/are allowed by the terms of the Trust to purchase, own and administer life insurance and securities;
   c) the Trust permits the Trustee(s) to exercise all ownership rights provided by any policy issued by The Company to the Trust, including, but not limited to, the right to surrender, pledge or encumber the policy or make withdrawals and the Trustee(s) is/are permitted to distribute the policy to any beneficiary of the Trust or to sell and transfer ownership of the policy pursuant to the sale;
   d) The Company may rely solely on this Certification and the statements and answers in the associated application as a basis for issuing and/or performing obligations of the policy, and neither The Company or anyone acting as an agent of The Company is responsible to determine the authority of the Trustee(s) or inquire into, or review the provisions of the Trust, and shall not be charged with knowledge of the terms of the Trust; and
   e) The Company may rely on the evidence submitted with respect to any change of the Trustee(s) and/or the appointment of a successor Trustee, and is not responsible to determine that the change or the appointment of any additional or successor Trustee(s) conforms with the Trust provisions.
   f) Beneficial interests under the Trust can and will only be established for persons who (i) are related to the Proposed Insured(s) by blood or by law, (ii) have a substantial interest in the Proposed Insured(s) engendered by love and affection, or (iii) hold a lawful and substantial economic interest in the continued life of the Proposed Insured(s).

TRUSTEE AUTHORIZATION

12. The undersigned Trustee(s) further certifies that in accordance with the Trust all documents related to the application for, issuance, delivery, exercise of rights of ownership and administration of the policy issued by The Company to the Trust must be signed by: (check one)
☐ ALL Trustees ☐ a MAJORITY of Trustees ☐ ANY Trustee or ☐ a DESIGNATED Trustee _____
Each Trustee understands and agrees that The Company shall rely on the above designation of authority to take action with respect to the policy and this designation of authority shall remain in effect until revoked by a written request of the Trustee(s) that is accepted and acknowledged by The Company.

SIGNATURES - All Grantor(s) and Trustee(s) must sign below.

Signed at City State | This Day of Year

X
Signature of Agent/Registered Representative (as Witness)

X
Signature of Trustee

X
Signature of Trustee

X
Signature of Grantor

X
Signature of Grantor

X
Signature of Trustee

John Hancock
the future is yours

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

IMPORTANT NOTICE:
Replacement of Life Insurance or Annuities (Standard Form)
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

This Important Notice must be read to the Owner. It must be signed by the Owner and the Agent/Registered Representative and a copy of the signed form left with the Owner. This Notice must be submitted with the Application for Life Insurance.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

3. ☐ I do not want this notice read aloud to me. _____ (Owner must initial only if this instruction applies.)
Initials

REPLACEMENT

Complete for all applicable policies to be replaced.

A **REPLACEMENT** occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, borrowed from an existing policy, forfeited, assigned to the replacing insurer, or otherwise terminated.

Please complete the following:

INSURANCE COMPANY _____ **POLICY NUMBER** _____

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

Continue list on another page if you have more than 3 existing policies.

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

a) Insured(s) _____

b) Owner _____

c) Issue Date _____
month day year

d) ☐ Group ☐ Personal ☐ Business

e) ☐ Annuity ☐ Life ☐ Term ☐ Endowment

f) 1035 Exchange? ☐ Yes ☐ No

Make sure you know the facts. Contact your existing company or its agent/registered representative for information about the old policy. (If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent/registered representative in the sales presentation. Be sure that you are making an informed decision.

AGENT'S STATEMENT

4. The existing policy or contract is being replaced because

REMINDER TO AGENT/REGISTERED REPRESENTATIVE: John Hancock's policy concerning replacement appears in the "Agent's Code of Conduct" and states: The "Replacement" of existing policies should only occur when it is demonstratively in the best interest of the client and in compliance with all applicable state and Company requirements. You must disclose all of the advantages and disadvantages of any replacement. The client must fully understand the financial consequences of this action and, where required by regulation, Company policy or industry practice, consent to it in writing. You must indicate on every application for new coverage whenever a replacement is involved in that sale.

REPLACEMENT ISSUES

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the cost and benefits of your existing policy and the proposed policy. One way to do this is to ask the company or agent that sold you your existing policy to provide you with information concerning your existing policy. This may include an illustration of how your existing policy is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies. You should discuss the following with your agent/registered representative to determine whether replacement or financing your purchase makes sense.

PREMIUMS

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid. You will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY

- If your health has changed since you bought your old policy, the new one could cost you more, or your application could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (Ask your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

COMPARISON OF EXISTING AND PROPOSED POLICY

ALL questions must be answered.

7. In comparison with the existing policy, indicate the appropriate answer to the following questions. On the new policy:

a) Is the guaranteed death benefit higher?	☐ Yes	☐ No	☐ Not applicable
b) Are the guaranteed cash values higher?	☐ Yes	☐ No	☐ Not applicable
c) Is the guaranteed interest rate higher?	☐ Yes	☐ No	☐ Not applicable
d) Is the face amount higher?	☐ Yes	☐ No	☐ Not applicable
e) Is the annual premium lower?	☐ Yes	☐ No	☐ Not applicable
f) Is the loan interest rate lower?	☐ Yes	☐ No	☐ Not applicable
g) Is the underwriting classification more favorable?	☐ Yes	☐ No	☐ Not applicable
h) Will any ownership problems be resolved?	☐ Yes	☐ No	☐ Not applicable
i) Will any beneficiary problems be resolved?	☐ Yes	☐ No	☐ Not applicable

You have a "free-look" period within which to examine the proposed policy. If you are not satisfied, you can return it for a full refund within the period stated in the new policy.

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or you may only be able to purchase it at substantially higher rates.

SIGNATURES

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

Signed at City State This Day of Year

Name of Owner (Please print) Signature of Owner

X

Name of Agent/Registered Representative as Witness (Please print) Signature of Agent/Registered Representative as Witness

X

ADDITIONAL OWNERS SIGNATURES IF MULTIPLE OWNERS

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

Name of Owner (Please print) Signature of Owner

X month day year

Name of Owner (Please print) Signature of Owner

X month day year

John Hancock

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

Financial Supplement for Personal Insurance

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

Print and use black ink.

Complete this form based on the following Proposed Insured(s) age and face amount.

Ages 0-65: $7,500,001+ Ages 66-79: $5,000,000+ Ages 80-90: $1,000,000+

SECTION A: Proposed Insured(s)

LIFE ONE

1. a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

LIFE TWO

2. a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

SECTION B: Income Information

3. a. Personal Income of Proposed Insured(s) (or Household in case of a Joint Life Application)

EARNED INCOME	PAST YEAR	TWO YEARS AGO	UNEARNED INCOME	PAST YEAR	TWO YEARS AGO
Salary	$	$	Dividends	$	$
Bonus or Commission	$	$	Interest	$	$
Spouse/Family Earned Income	$	$	Rents	$	$
Other	$	$	Other	$	$
	$	$		$	$
	$	$		$	$
Total	$	$	Total	$	$

If total line applied for with John Hancock is $10,000,000 or more, we may require documentation of asset values. We retain the right to require additional documentation and/or financial & tax statements for verification as needed.

SECTION C: Assets and Liabilities Information

4. a. Current net worth of the Proposed Insured(s). (Household if applicable)

Life One $_____ ☐ Personal ☐ Family Life Two $_____ ☐ Personal ☐ Family

If joint assets held, how much life insurance is in force for spouse: $ _____

b. Please provide breakdown of the assets and liabilities

ASSETS	
DESCRIPTION	AMOUNT
Cash in Banks	$
Stocks, Bonds, Securities	$
Accounts Receivable	$
Life Insurance (Cash Value)	$
Personal Property	$
Real Estate (Total)	$
Other Assets	$
	$
Total	$

LIABILITIES	
DESCRIPTION	AMOUNT
Unpaid Interest & Taxes	$
Notes Payable to Others	$
Accounts Payable	$
Life Insurance (Loans)	$
Mortgages on Real Estate	$
Other Long Term Debts	$
Other Liabilities	$
	$
Total	$

For any item representing over 25% of your total assets, we may require copies of latest statements of values.

SECTION C: Assets and Liabilities Information (continued)

4. c. Real Estate Assets

DESCRIPTION	ADDRESS	MARKET VALUE	HOW VALUE DETERMINED	OWNERSHIP	MORTGAGES
		$		%	$
		$		%	$
		$		%	$
		$		%	$
		$		%	$
	Total	$	Total	%	$

5. Is the policy applied for being funded by assets held in a trust? ☐ Yes ☐ No
If Yes, please identify which assets listed on page 1 or additional assets are held in the trust?

SECTION D: Signatures

I/We have read the completed Financial Supplement for Personal Insurance before signing below. All statements and answers in the Financial Supplement are correctly recorded and are complete and true to the best of my/our knowledge and belief as of the date of application for life insurance. I/We agree that this Financial Supplement constitutes a part of the insurance application and these statements and answers shall become part of the life insurance policy when issued. I/We understand that John Hancock Life Insurance Company (U.S.A.) will rely on the above statements in determining the need and justification for the insurance applied for. I/We understand that any false statements or material misrepresentations may result in loss of coverage under the policy.

I/We understand that any person who knowingly and with intent to defraud any insurer, files an application for insurance or statement of claim containing materially false information, or conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____
SIGNATURE OF PROPOSED INSURED ONE

X _____
SIGNATURE OF PROPOSED INSURED TWO

X _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

Financial Disclosure for Age 65 and Older

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

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

Policy No

- *For California residents only.*

Notice

This Notice is to advise you that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of the life insurance policy or annuity contract you are purchasing at this time may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation.

You may wish to obtain independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life insurance or annuity products.

Please give this page to the Owner.