



LIFE INSURANCE

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

Application for Term Life Insurance - Single Life
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 Life Insured and Owner.
Use the Additional Information/Special Requests section for additional space or special requests if required.

PROPOSED LIFE INSURED

1. a) Name First Middle Last b) Sex M F
c) Date of Birth Month Day Year d) Place of Birth State Country e) Social Security Number
f) Telephone Personal Business g) E-mail Address
h) Driver's License No. State i) Citizenship US Other - give details: (include U.S. Visa information)
j) Primary Residence Street Address City State Zip Code k) Total years at this address
l) Do you have a secondary residence? No Yes - provide address including zip code and months per year at this address in Additional Information Q 28.
m) Occupation Retired Homemaker Student Unemployed
n) Employer
o) Gross Annual Income Earned Unearned p) Net Worth Personal Joint with spouse
Financial Supplement for Personal Insurance NB5125 may be required.
q) Purpose of Insurance Estate Conservation Business Insurance - complete Business Insurance section Q 29
Wealth Transfer Income Replacement Other - give details:
r) In the last 5 years, has the Proposed Life Insured or any business of which he/she is a partner/owner/executive been bankrupt, had any liens, judgements or other similar financial difficulties? No Yes - give details:

OWNER - List additional Owners and details in Additional Information Q 28

2. Who is the Owner? Proposed Life Insured Business Partner
Trust Trust to be Established Employer
Other - give relationship to Proposed Life Insured

Provide details below, if other than Proposed Life Insured. If Trust Owner, complete the Trust Certification PS5101. Trust Agreement may be required.

3. a) Name b) Date of Birth/Trust Date Month Day Year
c) Address Street Address City State Zip Code
d) Social Security/Tax ID Number (if applicable) e) E-mail Address
4. Multiple Owners - Type of Ownership Joint with right of Survivorship Tenants in common

BENEFICIARY INFORMATION - Subject to change by Owner. (List additional beneficiaries in Additional Information Q 28)

5. a) Name Primary Relationship to Proposed Life Insured Percentage %
b) Name Primary Secondary Relationship to Proposed Life Insured Percentage %



**GENERAL RISK AND LIFESTYLE QUESTIONS - Provide details in Q 24 for 'Yes' answers.**

17. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)? If <b>'Yes'</b> , give details of type of nicotine product, amount and frequency and date last used in Q 24.	<input type="checkbox"/> No <input type="checkbox"/> Yes
18. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? If <b>'Yes'</b> give details of location (city/country), purpose, frequency and duration in Q 24.	<input type="checkbox"/> No <input type="checkbox"/> Yes
19. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes in the last 2 years? If <b>'Yes'</b> , complete <b>Aviation Questionnaire NB5009</b> . b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years? If <b>'Yes'</b> , complete appropriate <b>Avocation Questionnaire</b> .	<input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes
20. a) Have you been cited for one or more moving violations within the last 2 years? b) Have you been cited for driving while intoxicated or while otherwise impaired?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes
21. Have you ever been arrested, convicted, or imprisoned for a felony and/or currently awaiting trial for any crime and/or felony? If <b>'Yes'</b> give details of type, date, city/state of felony and/or crime and if currently on probation or parole in Q 24.	<input type="checkbox"/> No <input type="checkbox"/> Yes
22. Have any of your immediate family members (parents, brothers or sisters) died from coronary artery disease or cancer, prior to age 60?	<input type="checkbox"/> No <input type="checkbox"/> Yes
23. Are you a member of the armed forces, including the reserves? If <b>'Yes'</b> , complete <b>Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109</b> .	<input type="checkbox"/> No <input type="checkbox"/> Yes
24. Details for <b>'Yes'</b> answers for questions 17 - 23.	
Question No.	Details

**INFORMATION REGARDING LAST MEDICAL CONSULTATION**

25. a) Date of last visit to ANY doctor/physician	Month	Day	Year
b) Reason for and outcome of visit (Diagnosis / Treatment / Medication Prescribed)			
c) Physician Name, Address and Telephone Number			
d) Provide Primary Physician name and contact information, if different from 25 c).			

**MEDICAL CERTIFICATION**

26. Have you completed a life insurance para/medical examination? If <b>'Yes'</b> , complete chart below and Q 27. If <b>'No'</b> , proceed to Q 28.	<input type="checkbox"/> No <input type="checkbox"/> Yes
John Hancock Exam <input type="checkbox"/> OR Other Company's Exam <input type="checkbox"/>	Name of Other Insurance Company
	Date of Examination month                      year
27. Have you had any illness, injury, operation or treatment, or has there been any change in your health since the date of the examination? If <b>'Yes'</b> , give details in Additional Information/Special Requests Q 28.	<input type="checkbox"/> No <input type="checkbox"/> Yes

**ADDITIONAL INFORMATION/SPECIAL REQUESTS - Attach additional signed page if more space is required.**

28.

**COMPLETE THE FOLLOWING SECTIONS ONLY IF APPLICABLE TO YOUR APPLICATION**

**BUSINESS INSURANCE - Complete if face amount is under \$1,000,000. For face amounts \$1,000,000 and over complete the Financial Supplement for Business Insurance NB5124.**

29. a) Business Insurance Purpose  Key Person  Buy Sell  Business Loan  Other \_\_\_\_\_

	Assets	Liabilities	Gross Sales	Net Income	Fair Market Value of the Business
Current Year	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Previous Year	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

b) How was the amount applied for determined? \_\_\_\_\_

c) What percentage of the business is owned by the Proposed Life Insured? \_\_\_\_\_ %

d) Are other partners/owners/executives insured or applying for life insurance with any company?  
 No  Yes - give details: \_\_\_\_\_

**TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION  Not Applicable**

**Complete this section only if applying for Temporary Life Insurance and the criteria is met.**

Money may NOT be collected and the **Temporary Life Insurance Receipt and Agreement NB5004** may NOT be issued if:

- questions 30 to 32 are answered 'Yes' or left blank; or
- the Proposed Life Insured is under age 20 or over age 70; or
- the amount applied for is more than \$10,000,000.

30. Within the last 24 months, has the Proposed Life Insured under this application:

a) consulted a medical professional for, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession, for any heart problem, stroke or cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes
b) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?	<input type="checkbox"/> No <input type="checkbox"/> Yes
c) been declined for life insurance?	<input type="checkbox"/> No <input type="checkbox"/> Yes

31. Other than planned routine check-ups, are there medical concerns or symptoms for which a medical professional has not yet been consulted?  No  Yes

32. Does the Proposed Life Insured reside outside the United States more than 6 months per year?  No  Yes

**PRE-AUTHORIZED PAYMENT PLAN - To be completed by Owner  Not Applicable**

33. Request for Pre-Authorized Payment Plan  Yes

By selecting 'Yes', I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on this policy or any policies subsequently designated.

Checking Account No. \_\_\_\_\_ Routing No. \_\_\_\_\_

I understand and agree that:

- Such checks (which may include withdrawals made electronically) shall be drawn monthly to pay premiums falling due on the designated policies.
- While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
- The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
- The first premium paid must be submitted by check.**

**Attach voided sample check.**

**Attach Voided Check here**

**READ THE FOLLOWING CAREFULLY AND SIGN BELOW.**

**DECLARATIONS**

The Proposed Life Insured and Owner declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I 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 Life Insured will become part of the insurance policy issued as a result of this application.
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 Owner, provided that: (i) there has been no change in health or change in the lifestyle of the Proposed Life Insured, (ii) there has been no change in the financial circumstances of the Owner or the Proposed Life Insured, and (iii) nothing else 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 a change in health: (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.
3. **Employer Owned Policies:** The Proposed Life Insured confirms that they have received, prior to issue, written notice that indicates: a) the employer's intent to insure the Proposed Life Insured, (b) the maximum amount of the insurance to be issued on the life of the Proposed Life Insured and c) that the employer will be the beneficiary of the new policy. The Proposed Life 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 and with intent to defraud any insurer: a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
5. **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.**

**AUTHORIZATION TO OBTAIN INFORMATION**

I, the Proposed Life 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, insurance company, the MIB, Inc. or any other similar person or organization to give The Company and its reinsurers information about me. The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.
3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to give The Company and its reinsurers financial/net worth information about me.

I authorize The Company to disclose such information and any information developed during its evaluation of my application to: (a) its reinsurers; (b) the MIB, Inc.; (c) other insurance companies as designated by me; (d) me; (e) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (f) any medical professional designated by me; or (g) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB, Inc. This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

**SIGNATURES**

**X**

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

Owner - Signed at      City      State      This      Day of      Year

**X**

Signature of Proposed Life Insured if other than Owner

**AGENT SIGNATURE**

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

**X**

Signature of Agent/Registered Representative

Date



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Agent Report - Application for
Term Life Insurance - Single Life
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 Term Life Insurance - Single Life.

PROPOSED LIFE INSURED

1. Name

GENERAL INFORMATION

- 2. a) Total Premium Collected: \$ b) Has a Temporary Life Insurance Agreement been issued?
3. a) Have you personally met the Proposed Life Insured? b) Describe how the application was solicited and completed.

EMPLOYER OWNED POLICIES

- 4. a) Will this policy be owned by the employer of the Proposed Life Insured? b) The Proposed Life Insured has received written notice, which: c) The Proposed Life Insured has provided written consent to being insured and that such coverage may continue after the employment relationship terminates.

EXISTING AND REPLACING INSURANCE

- 5. Does the Owner have any existing life insurance and/or annuity policies? If 'Yes', the Agent/Registered Representative is required to present and read IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011 to the Owner.

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.

Table with 2 main sections (a and b) for agent information. Each section has columns for Name of Agent/Entity, BGA/Firm, Agent Code, % Share, Servicing Agent, Social Security No., Telephone No., and E-mail Address.

7. Name of Broker Dealer/ Wholesaler (if applicable)

CERTIFICATION AND SIGNATURE - An Agent/Registered Representative for this policy must sign this form.

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

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.

X

Signature of Agent/Registered Representative

Signed this Day of Year





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 197 Clarendon Street  
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## Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing

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

(hereinafter referred to as The Company)

### PROPOSED LIFE INSURED (LIFE ONE)

1. a) Name \_\_\_\_\_  
First Middle Last

b) State of Residence \_\_\_\_\_ c) Date of Birth \_\_\_\_\_  
month day year

### NOTICE - LIFE ONE

**The Tests:**

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of your blood, oral fluids or urine for testing and analysis. One of the tests to be performed on this sample may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure which is extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders. The testing will be performed by a licensed laboratory.

Your blood, oral fluids or urine sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat test is also positive, your blood, oral fluids or urine specimen will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA and a Western blot test.

**Disclosure of Test Results:**

All test results will be treated confidentially. The results of the test will be reported to the Insurer. The results also may be reported to its affiliates, reinsurers, or contractors in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific blood, oral fluids or urine abnormality may be made known to the Medical Information Bureau (MIB, Inc.) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you.

**Meaning of Test Results:**

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you are at seriously increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody positive should be considered infected with the AIDS virus and capable of infecting others. Positive HIV antibody test results will adversely affect your insurance application.

### CONSENT AND AUTHORIZATION

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, HIV Antibody Test Information is given on the reverse side of this form. I voluntarily consent to the withdrawal of blood from me by needle or the submission of oral fluids or urine sample, the testing of that blood, oral fluids or urine sample for HIV antibodies, and the disclosure of the test results as described above. I understand that this consent shall be valid for six months following the date shown below.

If the result of the test is positive, I hereby authorize that the result be disclosed to:

Check Appropriate Box

My physician \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street No. & Name Suite No. City State Zip code

The County Health Department Address \_\_\_\_\_  
Street No. & Name Suite No. City State Zip code

Myself directly

Signed at City State This Day of Year \_\_\_\_\_

Signature of Proposed Life Insured

**Company Copy - Please provide the Proposed Life Insured with a copy.**

**(See next page)**

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## HIV ANTIBODY TEST INFORMATION

### AIDS:

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs and contacts of any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

### The HIV Antibody Test:

Before you consent to testing, please read the following important information:

1. **Purpose.** This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.
2. **Positive Test Results.** If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.
3. **Accuracy.** An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:
  - a) **False positives:** The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high risk behavior. Retesting should be done to help confirm the validity of a positive test.
  - b) **False negatives:** The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive result to develop after a person is infected.
4. **Possible Adverse Effects of Test.** A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.
5. **Disclosure of Results.** A positive test result will be disclosed to you or the physician or county health department that you designate.
6. **Confidentiality.** Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to affiliates, reinsurers, employees and contractors of the insurer in relation to the underwriting of the insurance application. In addition, a report of a nonspecific blood, oral fluids or urine disorder may be made to the Medical Information Bureau, a national insurance data bank.
7. **Prevention.** Persons who have a history of high risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.
8. **Information.** Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotline within the Portland area at (503) 223-AIDS and outside the Portland area at 1-800-777-AIDS.



# 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**



**Request for Pre-Authorized Payment Plan**  
**John Hancock Life Insurance Company (U.S.A.)**  
*(hereinafter referred to as The Company)*

Service Office:  
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 197 Clarendon Street  
 Boston MA 02116-5010

Policy No. (for Internal Use Only)

**Proposed Life Insured (Life One)**

Name First Middle Last

**Proposed Life Insured (Life Two)**

Name First Middle Last

Name(s) of Owner(s)

**A voided sample check showing banking particulars must accompany this form.**

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		mmm	dd	yyyy	Premium	Loan

I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

- Such checks (which may include withdrawals made electronically) shall be drawn in the month to pay premiums falling due in such month on the designated policies.
- While the Pre-Authorized Checking Plan is in effect, The Company will not give notices of premiums falling due on such policies.
- The Pre-Authorized Checking Plan may be terminated by the bank depositor or by written notice to The Company by the undersigned. If the Pre-Authorized Checking Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.

**Signature(s) of Depositor(s) as shown on bank records for the account to which this Authorization is applicable**

Signed at City State This Day of Year

Signature of First Payor as shown on Bank Records

Signature of Second Payor as shown on Bank Records

**X**

**X**

Note: If a company is Payor, this agreement must be signed by an authorized officer stating title and affixing seal or stamp.



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**Notice of Disclosure of Information**  
**John Hancock Life Insurance Company (U.S.A.)**  
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Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s).

**PROPOSED LIFE INSURED(S)**

**LIFE ONE**

1. Name \_\_\_\_\_

First

Middle

Last

**LIFE TWO**

2. Name \_\_\_\_\_

First

Middle

Last

**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 you provide will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB will supply such company with the information it may have in its files.

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 (TTY 866-346-3642). 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 given in your application and information in its file to other life 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](http://www.mib.com).

**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.

**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 Life Insured with a copy.**



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**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.

**RECEIPT**

The Company acknowledges receipt of \$ \_\_\_\_\_

paid in connection with the Application for Life Insurance dated \_\_\_\_\_  
month day year

on **PROPOSED LIFE INSURED (LIFE ONE)**

**PROPOSED LIFE INSURED (LIFE TWO)**

1. Name \_\_\_\_\_  
First Middle Last

2. Name \_\_\_\_\_  
First Middle Last

3. Name of Owner \_\_\_\_\_

\_\_\_\_\_  
month day year **X**  
Signature of Agent/Registered Representative

**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 Life Insured, or the Surviving Proposed Life 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.** No coverage will be provided under this Agreement if any of the following apply:
  - (a) any of the questions in the Temporary Life Insurance Agreement Application are answered "Yes" or left blank; or,
  - (b) any Proposed Life Insured is under age 20 or over age 70 (nearest birthday) 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 Life Insurance is more than \$10,000,000 of individual 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 Life 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 Life Insured's employment) unless prescribed by a licensed doctor other than the Proposed Life 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**



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

**IMPORTANT NOTICE:**  
**Replacement of Life Insurance or Annuities (Model Regulation)**  
**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**

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

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

A **FINANCED PURCHASE** occurs when the purchase of a new policy involves the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from, values of an existing policy to pay all or part of any premium due on a new policy. A financed purchase is a replacement.

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

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

- 4. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract?  No  Yes - give details below
- 5. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?  No  Yes - give details below

If you answered 'Yes' to either of the above questions, complete the following information for each existing policy or contract you are contemplating replacing.

**Complete for all applicable policies to be replaced.**

**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)  Replacement  Financing
- g) 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)  Replacement  Financing
- g) 1035 Exchange?  Yes  No

## REPLACEMENT continued

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

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)  Replacement  Financing
- g) 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

6. The existing policy or contract is being replaced because \_\_\_\_\_

**Note: Confirmation of Marketing Materials, NB5012** must also be completed.

**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





# Agent Certification

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

*(hereinafter referred to as The Company)*

• This form must be completed if the sale is a survivor universal life policy to a qualified profit sharing plan.

Name of Agent

Name of Plan

Names of Insured(s)

I, the undersigned agent, certify to John Hancock Life Insurance Company (U.S.A.) (The Company) that the following conditions have been met for issuance of a Survivorship Universal Life (SUL OR SVUL) policy to the

Name of Plan (the "Plan")

1. The Plan document allows the Plan to own and hold insurance on the life of a participant and a non-participant at the election of the participant.
2. The Plan allows the participant to select the insurer.
3. The insureds are the participant and the participant's spouse.
4. A spousal waiver of benefit has been filed with the Plan's administrator.
5. The beneficiary of the policy is the Plan trustee.
6. The purchase of the policy will not violate the "incidental benefit rule" of Internal Revenue Code Regulation Section 1.401-1(b) and guidance issued by the Internal Revenue Service.
7. The "Certification by Trustee", form NB4804US, has been signed.
8. The "Fiduciary Approval", form NB4805US, has been signed.
9. The insureds have not relied upon the Company or anyone acting on behalf of The Company to determine whether the purchase of life insurance and whether the amount of life insurance purchased are appropriate for the insureds or for the Plan.
10. The insureds are being advised by a tax and/or legal advisor. The advisor's name, address and phone number are:

Name of Advisor

Address of Advisor

Street No. and Name	Suite No.
City	State <span style="float: right;">Zip Code</span>

Telephone Number of Advisor

I understand that failure to comply with the requirements above and the referenced forms could result in the disqualification of the Plan and cause adverse federal and state income tax consequences to the participant and/or the Plan.

### Signature

Signed at

This

Day of

Year

Signature of Agent