



LONG-TERM CARE
INSURANCE

New Business Coverage Change Form

Fax: 800-932-4305

Please note options and riders listed below may not be available on your policy; please refer to the product guidelines for availability of riders and options prior to completing this request and additional underwriting may be needed.

Part 1: Policy Information

Insured's Name _____ Policy Number _____

Part 2: Select how you wish to see these changes

- Full Policy and Schedule of Benefits "Page 3"
- Schedule of Benefits "Page #3" Only

Part 3: Please check the change to be made and provide details or additional documentation if needed.

GENERAL CHANGES

- Sponsored Group Discount
Membership Verification Form required (LTC-3192)
- Valued Client Discount
Verification of Status Form required (LTC-2978)
- Effective Date Change (mm/dd/yyyy) _____

PAYMENT METHOD CHANGES

- Direct Bill
- Annual
- Monthly Bank Draft
(copy of voided check & ADP form required 7269R)
- Credit Card
(credit card authorization required (CCAATH or CCAATH LE)
- Semi-Annual
- Quarterly

BENEFIT, OPTION OR RIDER CHANGES

- Benefit Amount (CCI, CCII, CCIIIE, LE) \$ _____
- Benefit Period (CCI, CCII, CCIIIE, LE) _____
- Benefit Increase (Inflation) Option (All) _____
- Home Health Care Daily (ECI, ECII) _____
- Nursing Home Daily Benefit (ECI, ECII) _____
- Elimination Period (ECI, ECII, CCI, CCIIIE) _____
- SharedCare (All) Add Remove
- Nonforfeiture (All) Add Remove
- Survivorship/Waiver of Premium (CCI, CCIIIE) Add Remove
- Waiver of EP for HHC (CCI, CCII, CCIIIE) Add Remove
- Zero-Day Elimination Period (LE) Add Remove
- Enhanced Return of Premium (CCII, CCIIIE) Add Remove
- Additional Cash Benefit (CCI, CCII, CCIIIE) Add Remove
- Restoration of Benefits (CCI, CCII, CCIIIE) Add Remove
- Residential Care Facility (CCII, CCIIIE) Add Remove
- Paid-Up at Age 65 Limited Payment (All) Add Remove
- 10-Year Limited payment (All) Add Remove
- Other: _____

I hereby declare that I understand the nature of the changes requested above and that the information stated above is true and complete to the best of my knowledge. I agree that any change will become effective on the date set by John Hancock following receipt of this request.

Signature of Policyholder _____ Print Name of Policyholder _____ Date _____

Signature of Licensed Agent _____ Print Name of Licensed Agent/Firm/Agency Number _____ Date _____

If the coverage change is being requested by a licensed agent, we will require a signed authorization by the policyholder within 60 days of this change. Note: Decreasing benefits on your policy may change your policy's Partnership status. Consult with your producer or John Hancock about possible ways to retain Partnership status. This form can be used to reduce coverage only. Any requests to increase coverage after 6 months of issue requires a new application and underwriting review. Refer to your individual contract for available benefits as all options listed above may not be available for your plan and/or state.

Long-term care insurance is underwritten by John Hancock Life Insurance Company (U.S.A.), Boston, MA 02117 (not licensed in New York) and in New York by John Hancock Life & Health Insurance Company, Boston, MA 02117.