Leading Edge Application
PRODUCER INSTRUCTIONS – NEW YORK

Certain forms contained in this booklet allow for two applicants (A and B) to complete and sign. Others require separate completion and signature. Where only one applicant is applying, please enter responses as "Applicant A".

Follow the Checklist and Instructions below to ensure a smooth and timely application process. All state required disclosure information must be presented to your client (s) prior to an application form.

Please review the Condensed Underwriting Guide LTC-1727 to determine your client's eligibility. It is critical to provide the Underwriting Process Brochure LTC-1590 to your clients to prepare them for the underwriting process.

CHECKLIST

✓	Form Name	Form #	Can two applicants use the same form?	Action
Application and Required Forms (included in this booklet)				
	Application Form	LTCAPP06 NY	Yes	All answers to questions on the application form must be completed or checked off, both for affirmative and negative responses, including the rejection of nonforfeiture. Read all questions carefully. The applicant(s) must sign and date page 7. The producer must sign and date page 8. Backdating is not permitted.
	Advance Payment Receipt	LTCCR-06 NY	Yes	The amount of the advance payment is to be recorded and the producer must sign and date this form. We ask that the date on this form and check match the date of the application form. Submit one copy with the application. Leave one copy with the applicant(s).
	HIPAA Medical Authorization	LTCMED-06	No. (Separate versions provided for Applicants A and B)	This form must be signed and dated by the applicant(s) and submitted with the application in order for the underwriting process to begin. We ask that the date on this form match the date of the application form. **We cannot accept an altered document.**
	Replacement Form (if applicable)	15-LTC-06 NY	Yes	If replacing another long-term care insurance policy, use of this form is mandatory. The applicant(s) and producer must sign. Submit one copy with the application. Provide one copy to the applicant(s).
	Certification of Domestic Partnership	LTC-DPC 9/03	Yes	Both partners must sign if seeking the Partner Discount. Submit with the application form.
	Suitability Personal Worksheet	LTC-PWK NY 6/06	No. (Separate versions provided for Applicants A and B)	Attempt to review your client's income and assets to determine if our minimum suitability standards are met. The applicant(s) and producer must complete, sign, date and submit with the application.
	Suitability Information Sheet	LTC-SUIT 6/06	Yes	Provide a copy to the applicant(s).
	Outline of Coverage	OCLTC-06 NY	Yes	Prior to presentation of an application form, provide a completed Outline to applicant(s).
	Notice of Insurance Practices	LTC-INF 10/00	Yes	Provide a copy to the applicant(s).
	Notice of Protected Health Information Privacy Practices	OCP1000 RLTC	Yes	Provide a copy to the applicant(s).
	Medicare Disclosure	LTC-96-Med 9/96	Yes	Provide a copy to the applicant(s).
Buyers Guides (not included in this booklet)				
	NAIC LTC Shoppers Guide	LTC-1059	Yes	Provide a copy to the applicant(s).
	Guide to Medicare for People Age 65 & Older	LTC-1014	Yes	Provide a copy applicants aged 65 and older, or who are Medicare eligible.

INSTRUCTIONS

1. Submit a copy of the premium illustration quote with the application form.
2. The application and all required forms must be received by John Hancock's home office within 30 days of the date the application was signed by your client. Incomplete applications and missing forms cause delays in the process and may be returned.
3. Use a black or blue ink pen. Draw a line through any errors made and have the applicant initial any corrections (**Do not use white-out**).
4. If the applicant has answered "yes" to any question in Part I (*Should You Proceed with this Application?*) of the application, he / she may be considered uninsurable. You may not want to submit the application.
5. Please note that if the applicant's birthday is within 30 days of the signature date, we will preserve the younger age.
6. The "Credit for Application" under Part XII must include your firm's name and your own social security number to ensure proper commission payments.
7. An initial deposit is required with each application, equal to no less than *one monthly modal* premium. The Advance Payment Receipt must be completed.
8. Any applicable state-required forms are included in this application booklet (except for buyer's guides); please be sure you are using the correct state specific application booklet. Review all forms with the applicant.
9. Confirm that the application and all required forms have been signed where required and dated in all appropriate sections.

For Home Office Use Only: | Control Number A: | Control Number B:

APPLICATION FOR INDIVIDUAL LONG TERM CARE INSURANCE

John Hancock Life Insurance Company, Boston, MA 02117

The applicant must initial any corrections made to this application.

NAME(S): Applicant A (First, M.I., Last)	Applicant B (First, M.I., Last)*

***Applicant B refers Applicant A's Spouse or Partner.** "Partner" means the unmarried person who is not related to you with whom you have lived in a committed relationship for at least 3-years prior to the date you complete this application. You & your Partner must both complete the New York Domestic Partner Declaration form or an alternative affidavit appropriate to the jurisdiction where your partnership was established.

PART I SHOULD YOU PROCEED WITH THIS APPLICATION?

	Question	Applicant A		Applicant B	
1	To the best of your knowledge and belief, do you have or have you been advised by a member of the medical profession that you have any of the following: Alzheimer's Disease, Huntington's Chorea, Multiple Sclerosis, Schizophrenia, Amyotrophic Lateral Sclerosis, Memory Loss, Muscular Dystrophy, Scleroderma, Cystic Fibrosis, Mental Retardation, Myasthenia Gravis, Spinal Cord Injury, Dementia, Multiple Myeloma, Parkinson's Disease, Stroke/CVA	❑ Yes	❑ No	❑ Yes	❑ No
2	Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	❑ Yes	❑ No	❑ Yes	❑ No
3	Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	❑ Yes	❑ No	❑ Yes	❑ No
4	Do you currently use one of the following medical devices: wheelchair; walker; hospital bed; quad cane; oxygen; stairlift; or dialysis?	❑ Yes	❑ No	❑ Yes	❑ No
5	Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	❑ Yes	❑ No	❑ Yes	❑ No

◆ **Please do not continue with this application if you answered "Yes" to any of questions 1-5 above.**

	Question	Applicant A		Applicant B	
6	Are you covered by Medicaid (not Medicare)?	❑ Yes	❑ No	❑ Yes	❑ No

PART II ABOUT YOU

Applicant A (named above)	**Applicant B (named above)**
Social Security # Male ❑ Female ❑	Social Security # Male ❑ Female ❑
Date of Birth (mm/dd/yyyy) Place of Birth (State, Country)	Date of Birth (mm/dd/yyyy) Place of Birth (State, Country)
Street Address (no P.O. Box please)	Street Address ❑ Same as Applicant A
City County State Zip	City County State Zip
Tel. # Best time to call Home: Work/Cell: ___ AM ___ PM	Tel. # Best time to call Home: Work/Cell: ___ AM ___ PM
Email Address	Email Address

PART III MEDICAL HISTORY

	Applicant A	Applicant B
1 Have you consulted with your Primary Care Physician within the last 18 months?	❑ Yes ❑ No	❑ Yes ❑ No

Applicant A: Primary Care Physician Name: ______

Address: ______

City, State, Zip Code: ______

Tel. #: ______

Date Last Seen: ______

Applicant B: Primary Care Physician Name: ______

Address: ______

City, State, Zip Code: ______

Tel. #: ______

Date Last Seen: ______

	Applicant A	Applicant B
2 Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
3 What is your height?	►	►
4 What is your weight?	►	►
5 To the best of your knowledge and belief, within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?		
a) **Circulatory Disorders:** Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms	❑ Yes ❑ No	❑ Yes ❑ No
b) **Endocrine and Pituitary Disorders:** Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease	❑ Yes ❑ No	❑ Yes ❑ No
c) **Cancers:** Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas	❑ Yes ❑ No	❑ Yes ❑ No
d) **Genitourinary Disorders:** Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders	❑ Yes ❑ No	❑ Yes ❑ No
e) **Gastrointestinal Disorders:** Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders, Cirrhosis	❑ Yes ❑ No	❑ Yes ❑ No
f) **Blood Disorders:** Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis	❑ Yes ❑ No	❑ Yes ❑ No
g) **Neurological Disorders:** Cerebral Atrophy, Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome	❑ Yes ❑ No	❑ Yes ❑ No
h) **Musculoskeletal Disorders:** Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Osteopenia, Polymyalgia Rheumatica, Paralysis, Crest	❑ Yes ❑ No	❑ Yes ❑ No
i) **Respiratory Disorders:** Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease	❑ Yes ❑ No	❑ Yes ❑ No
j) **Eye & Ear Disorders:** Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo	❑ Yes ❑ No	❑ Yes ❑ No
k) **Substance Abuse:** Alcoholism, Drug dependency, Illicit drug use	❑ Yes ❑ No	❑ Yes ❑ No
6 Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?	❑ Yes ❑ No	❑ Yes ❑ No
7 Within the last 5 years has any surgery or test(s) been recommended that has not been performed?	❑ Yes ❑ No	❑ Yes ❑ No
8 Have you ever had an application for life, accident, medical or health, disability or long term care insurance declined, postponed, modified or rated?	❑ Yes ❑ No	❑ Yes ❑ No
9 Are you receiving any disability benefits?	❑ Yes ❑ No	❑ Yes ❑ No
If Yes, provide the disability %:	%	%

PLEASE NOTE: You may be contacted by a nurse on John Hancock's behalf to review your medical history and other information including height, weight, and blood pressure verification.

10 MEDICAL HISTORY DETAILS **If you answered "Yes" to any of questions 5-9 in Part III above, please provide full details here (attach an additional signed and dated page if necessary).**

Quest. #	Diagnosis, Disorder and/or Reason	Diagnosis Date	Treatment Dates	Name, Address, Tel. # of Physician, Provider and/or Insurer (if applicable), and Explanation or Comments
APPLICANT A				
APPLICANT B				

11 MEDICATIONS **List all prescription medications taken at any time over the past 12 months.**

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name
APPLICANT A				
APPLICANT B				

PART IV COVERAGE SELECTION

		Applicant A	Applicant B
1	**Benefit Amount** (choose either Daily or Monthly):	❑ **Daily Benefit Amount**	❑ **Daily Benefit Amount**
	$100 - $500 in $10 increments (Metropolitan area) $70 - $500 in $10 increments (Non-Metropolitan area)	$	$
	OR	❑ **Monthly Benefit Amount**	❑ **Monthly Benefit Amount**
	$3,100 - $15,500 in $100 increments (Metropolitan area) $2,200 - $15,500 in $100 increments (Non-Metro area)	$	$
2	**Benefit Period** (Years): * The 5 Plus option is a 5-year Benefit Period plus the $1 Million Rider.	❑ **3** ❑ **5** ❑ **5 Plus***	❑ **3** ❑ **5** ❑ **5 Plus***
3	**Optional Riders:**		
	▪ SharedCare	❑	❑
	▪ Zero-Day Elimination Period for Home Care	❑	❑
	▪ Nonforfeiture (if rejected, see also 3a below)	❑	❑

3a) Rejection of Nonforfeiture (if applicable):
I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.

	Applicant A	Applicant B
► You **must** check this box if you have **NOT** elected Nonforfeiture.	❑	❑

PART V DISCOUNTS

You may be eligible for discounts.

		Applicant A	Applicant B
	Marital/Partner Discount		
1	Are you married? **OR**	❑ Yes ❑ No	❑ Yes ❑ No
2	If you are not married, are you in a committed relationship with a Partner with whom you have been living together for a period of at least 3 years? *(If "Yes", You and your Partner must both complete the New York Domestic Partner Declaration form or an alternative affidavit appropriate to the jurisdiction where your partnership was established.)*	❑ Yes ❑ No	❑ Yes ❑ No
3	Is your Spouse or Partner also applying for this insurance, or does he/she currently have an existing John Hancock individual long term care insurance policy?	❑ Yes ❑ No If Yes, Policy # ____________	❑ Yes ❑ No If Yes, Policy # ____________
	Marketing Group Discount		
4	Do you belong to a marketing group? ►	❑ Yes ❑ No	❑ Yes ❑ No
	Please provide proof of employment/ membership with the marketing group.	If Yes, Group #:	
		Group Name:	

PART VI CHOOSE YOUR PAYMENT METHOD

1 ALTERNATE PAYOR(S) IF DIFFERENT THAN APPLICANT(S)

Applicant A	Applicant B ❑ Same as Applicant A
Name (First, M.I., Last)	Name (First, M.I., Last)
Billing Address	Billing Address
City State Zip	City State Zip
Tel. #:	Tel. #:

2 CHOOSE ONE OF THE FOLLOWING PAYMENT METHODS FOR EACH APPLICANT

		Applicant A	Applicant B
a) Direct Bill *	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
b) Monthly Bank Draft *	(Please check box ►)	❑	❑
Please include a voided check.	Select Draft Date (1-28):		
	Bank Account #:		
❑ Check here if bank draft information is the same for both Applicants A and B.	Account Type:	❑ Checking ❑ Savings	❑ Checking ❑ Savings
The first draft will occur on the premium due date after the policy has been issued. Subsequent drafts will occur on the selected draft date requested above.	Bank Name:		
	Bank Routing Number:		
	Name(s) of Depositor(s)		
*** An advance check payment is required for Direct Bill / Monthly Bank Draft.** I have enclosed my advance payment in the amount of:		$	$
Please make your check payable to 'John Hancock Life Insurance Company'.		(A minimum of one month of the quoted premium)	
c) Credit/Debit Card	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
	Monthly	❑	❑
❑ Check here if the card information is the same for both Applicants A and B.	Card Type:	❑ Visa ❑ Mastercard	❑ Visa ❑ Mastercard
	Card Number:		
	Expiration Date:		
	Cardholder's Name:		
d) List Bill	(Please check box ►)	❑	❑
	Group Number:		
	Group Name:		

3 LIMITED PAYMENT OPTION

	Applicant A	Applicant B
10-Year Limited Payment Option, **OR**	❑	❑
Paid-Up at Age 65 Limited Payment Option	❑	❑

PART VII DESCRIBE YOUR INSURANCE HISTORY

	Applicant A		Applicant B	
1 Have you had another long term care insurance nursing home and home care, nursing home only, home health care policy or certificate in force during the last 12 months?	❑ Yes	❑ No	❑ Yes	❑ No
If yes, insurance company:				
If now lapsed, date of lapse:				
2 Do you have another long term care nursing home and home care, nursing home only, home health care, accident & health insurance policy or certificate in force (including a health care service, health maintenance, or Medicare supplement contract)?	❑ Yes	❑ No	❑ Yes	❑ No
If yes, insurance company:				
Policy/Cert. #:				
Annual premium:				
Daily benefit:	$		$	
Benefit type & amounts:				
3 Do you intend to replace any of your long term care, nursing home and home care, nursing home only, home health care medical or health insurance coverage with the policy for which you are applying?	❑ Yes	❑ No	❑ Yes	❑ No
If yes, insurance company:				

PART VIII SPECIAL REQUESTS:

PART IX PROTECTION AGAINST UNINTENDED LAPSE (Check one box below for each applicant.)

I understand that I have the right to name another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A	Applicant B
❑ I elect NOT to designate any person to receive such notice, or ❑ I elect to designate the person below to receive such notice.	❑ I elect NOT to designate any person to receive such notice, or ❑ I elect to designate the person below to receive such notice.
Name of Person (First, M.I., Last)	Name of Person (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip

PART X MAKE DECLARATIONS AND PROVIDE AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

a. I have received the Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Shopper's Guide to Long term Care Insurance and a Replacement Notice (if replacing coverage), and the "Guide to Health Insurance for People with Medicare" (if eligible for Medicare).
b. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
c. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
d. John Hancock Life Insurance Company ("John Hancock") may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
e. My statements and answers on this application are true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, JOHN HANCOCK HAS THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

a. Completing this application or making an advance payment is not a guarantee that my application will be approved. If approved, the effective date will be indicated in the policy issued.
b. If my application is declined, the long term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.
c. If making an advance payment, my check(s) will be held in a non-interest bearing account while John Hancock reviews this application for acceptance.
d. By making an advance payment by check or by providing a credit card authorization with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. And, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen.
   The following provision is applicable to payroll deduction, list-billed or employer-paid plans where no advance payment is required: I understand that my health status will not be frozen when no advance payment is made. I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.)
e. If bank draft is the selected method of payment, the first draft will occur on the premium due date after my policy has been issued. Subsequent drafts will occur on the selected draft day requested in Part VI of this application.
f. In order to keep my policy in force, I must pay all the required premiums when due. The premiums deducted or charged will be as shown on the policy or the most recent premium change notice issued to the policyholder by John Hancock.
g. I authorize John Hancock to deduct from my bank or charge my credit/debit card all required premiums, based upon my selected method of payment as shown in Part VI, indefinitely until I provide written notice of cancellation to John Hancock at the servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

Fraud Notice. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

Applicant(s): I have reviewed this application including all elections and answers contained within. By my signature, I affirm all my elections and answers in this application.

X	X
Signature of Applicant A	Signature of Applicant B
Signed At: (City & State) Date	Signed At: (City & State) Date

PART XI PRODUCER/AGENT'S STATEMENT

	Applicant A	Applicant B
► **Please indicate the Underwriting Risk classification quoted:**	❑ Preferred ❑ Select	❑ Preferred ❑ Select
Note: Underwriting will determine the appropriate risk class, regardless of that quoted to the applicant. We will communicate any change to you.		
Replacement: I have reviewed the current accident and health insurance coverage of the applicant and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for the applicant's needs.To the best of my knowledge, replacement of other insurance (check box) involved in this transaction.	❑ is / ❑ is not	❑ is / ❑ is not

Listed below are all other health insurance policies I have (i) sold to the Applicant which are still in force; and (ii) sold to the Applicant in the last five years which are no longer in force.

Applicant A/B	Company	Type of Policy	Effective Date	In Force?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Signature of Licensed Agent: ____________________

Agent Name (Please print): ____________________ Date: __________

Please attach the illustration presented to the Applicant(s).

PART XII CREDIT FOR APPLICATION

Please complete as much as possible to facilitate correct credit.

Agency/Bank/Firm Name: ____________________

Secondary Firm Name (if applicable): ____________________

Producer/Agent Name (Please print): ____________________

Producer SS#: ____________________

Tel. #: ____________________

Fax Number: ____________________

Email: ____________________

To be completed by JHFN producers only:

Agency Code (if known): __________

Payroll Number: __________

Contract Code: __________

If more than one producer was involved in this sale, provide details here:

Producer Name: ____________________ Percentage: ______

Producer SS#: ____________________

Agency/Firm: ____________________

Producer Name: ____________________ Percentage: ______

Producer SS#: ____________________

Agency/Firm: ____________________

Producer Name: ____________________ Percentage: ______

Producer SS#: ____________________

Agency/Firm: ____________________

Advanced Payment Receipt

John Hancock Life Insurance Company

Received: $____________________

Applicant A Name: ________________________________

Applicant B Name: ________________________________

Requirements:

- You must make your advance payment by check (payable to 'John Hancock Life Insurance Company') or by providing a credit card authorization. Do not make checks payable to the agent or leave the payee section blank.
- The advance payment must be equal to a minimum of one month of the quoted premium.
- Your check will be held in a non-interest bearing account while we underwrite your application.

Thank you for your advance premium payment. This section explains why an advance payment is so important to you.

By making an advance payment with this application, any change in your health status after the later of the following:

i. the date of this Receipt, or

ii. the date you complete any physical exams or tests required by us,

will not affect the underwriting of your application.

This means that if you become ill, impaired or injured after the later of these dates, we will not consider such change in health in our underwriting process. Adverse changes in the company's underwriting rules after the Receipt Date will not affect insurability.

Please note that completing this application and making an advance payment does not guarantee that your application will be approved or that you will become insured.

If your application is approved, the long term care insurance policy for which you applied will be issued to you. Coverage will become effective on the date the application is signed/completed or a later date selected by you. The effective date of your coverage will be stated in the policy issued and delivered to you. To keep your policy in force you must pay all the required premiums when due.

If your application is declined, the long term care insurance coverage you applied for will not become effective, and any advance payment submitted with the application will be refunded to you immediately, without interest.

On behalf of John Hancock Life Insurance Company:

Agent Signature: ________________________________

Date: __________________

Return to Insurer

Advanced Payment Receipt

John Hancock Life Insurance Company

Received: $____________________

Applicant A Name: ________________________________

Applicant B Name: ________________________________

Requirements:

- You must make your advance payment by check (payable to 'John Hancock Life Insurance Company') or by providing a credit card authorization. Do not make checks payable to the agent or leave the payee section blank.
- The advance payment must be equal to a minimum of one month of the quoted premium.
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i. the date of this Receipt, or

ii. the date you complete any physical exams or tests required by us,

will not affect the underwriting of your application.

This means that if you become ill, impaired or injured after the later of these dates, we will not consider such change in health in our underwriting process. Adverse changes in the company's underwriting rules after the Receipt Date will not affect insurability.

Please note that completing this application and making an advance payment does not guarantee that your application will be approved or that you will become insured.

If your application is approved, the long term care insurance policy for which you applied will be issued to you. Coverage will become effective on the date the application is signed/completed or a later date selected by you. The effective date of your coverage will be stated in the policy issued and delivered to you. To keep your policy in force you must pay all the required premiums when due.

If your application is declined, the long term care insurance coverage you applied for will not become effective, and any advance payment submitted with the application will be refunded to you immediately, without interest.

On behalf of John Hancock Life Insurance Company:

Agent Signature: ________________________________

Date: __________________

Applicant(s) Copy

LTCCR-06 NY

PART X # HIPAA MEDICAL AUTHORIZATION

Applicant A

<u>This is a HIPAA-compliant authorization</u>.

"HIPAA" stands for The Health Insurance Portability and Accountability Act of 1996, as amended.

Agreement: I understand and agree that:

a) If I do not sign this authorization, John Hancock may decline my application; decline to pay my claim for benefits; and decline to provide health information about me to my doctor(s) or the individual(s) / entity(ies) named below.
b) My authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
c) My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
d) A copy of this authorization is as valid as the original.
e) This authorization expires within 24 months from the date I sign it.

Authorization: I authorize:

a) The use and disclosure of my medical records and medical history and other information that relates to: (a) the diagnosis of any physical or mental condition, and (b) the treatment or prognosis of any physical or mental condition, whether this information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or sexually transmitted diseases.
b) The following persons or entities are authorized to disclose health information about me: a doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life Insurance Company (John Hancock)); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.
c) The disclosure of my health information to John Hancock and its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency.
d) The use and disclosure of my health information in connection with this application, to determine the premium for my long term care insurance, to service my long term care insurance coverage, and to evaluate my claim for long term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.
e) The disclosure of my health information to my doctor(s) or other individual(s) as named below:

Doctor/Individual Name (First, M.I., Last)	Doctor/Individual Name (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip
Tel. #:	Tel. #:

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included:

X

Print Name of Applicant A	Signature of Applicant A	Date

PART X HIPAA MEDICAL AUTHORIZATION

Applicant B

<u>This is a HIPAA-compliant authorization</u>.

"HIPAA" stands for The Health Insurance Portability and Accountability Act of 1996, as amended.

Agreement: I understand and agree that:

a) If I do not sign this authorization, John Hancock may decline my application; decline to pay my claim for benefits; and decline to provide health information about me to my doctor(s) or the individual(s) / entity(ies) named below.

b) My authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.

c) My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.

d) A copy of this authorization is as valid as the original.

e) This authorization expires within 24 months from the date I sign it.

Authorization: I authorize:

a) The use and disclosure of my medical records and medical history and other information that relates to: (a) the diagnosis of any physical or mental condition, and (b) the treatment or prognosis of any physical or mental condition, whether this information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or sexually transmitted diseases.

b) The following persons or entities are authorized to disclose health information about me: a doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life Insurance Company (John Hancock)); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.

c) The disclosure of my health information to John Hancock and its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency.

d) The use and disclosure of my health information in connection with this application, to determine the premium for my long term care insurance, to service my long term care insurance coverage, and to evaluate my claim for long term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.

e) The disclosure of my health information to my doctor(s) or other individual(s) as named below:

Doctor/Individual Name (First, M.I., Last)	Doctor/Individual Name (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip
Tel. #:	Tel. #:

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included:

X

Print Name of Applicant B **Signature of Applicant B** **Date**

John Hancock Life Insurance Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE AND THE PURCHASE OF MULTIPLE ACCIDENT AND HEALTH POLICIES

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by John Hancock Life Insurance Company. Your new policy provides (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information requested on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on: __________

____

Applicant A’s Signature

____

Applicant B’s Signature

I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant’s needs.

____

Signature of Agent, Broker or Other Rep.

____

Print Name of Agent, Broker or Other Rep.

Return to Insurer

John Hancock Life Insurance Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE AND THE PURCHASE OF MULTIPLE ACCIDENT AND HEALTH POLICIES

According to your application and information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by John Hancock Life Insurance Company. Your new policy provides (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.
3. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information requested on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on: __________

____

Applicant A’s Signature

____

Applicant B’s Signature

I have reviewed the current health insurance coverage of the applicant and find that replacement and/or additional coverage of the type and amount applied for is appropriate for the applicant’s needs.

____

Signature of Agent, Broker or Other Rep.

____

Print Name of Agent, Broker or Other Rep.

Applicant(s) Copy

15-LTC-06 NY

New York Domestic Partner Declaration

We, the undersigned, hereby certify that the following statements are correct and true.

- We are both 18 years of age or older and are mentally competent to consent to contract;
- We are not married or legally separated from anyone else;
- We are not related by blood in a manner that would bar marriage under the laws of the state of New York;
- We have been living together on a continuous basis prior to the date of the application; and
- Neither of us has been registered as a member of another domestic partnership within the last six months.

______________________________	______________________________
Signature	Signature
______________________________	______________________________
Print Name	Print Name

Long-Term Care Insurance Personal Worksheet

Applicant A

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

The purpose of this worksheet is to help you and us decide if you should buy this policy.

Premium Information

Policy Form Number: ____________________________________

The premium for the coverage you are considering will be $________ per ___________.

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums: John Hancock Life Insurance Company has a right to increase premiums on this policy form in the future, provided we raise rates for all policies in the same class in this state.

Rate Increase History

John Hancock has sold individual long-term care insurance since 1987 and has sold this John Hancock policy since 2006.

In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company block of individual long-term care insurance. John Hancock raised the premiums rates on the Fortis policy series listed below:

States	Fortis Policy Series	Years Fortis Policy Series was Available for Purchase	Fortis Policy Series Rate History
CA, FL, IL, IA, KS, KY, MO, NE, ND, OH, SD & TX.	Policy series 4040, 4042 & 4043; With associated riders 2020, 2021, 2022 & 2023 (where applicable)	1993 - 1997	30% increase in 2003
All states (except AK, DC, HI, ID, IA, KS, MA, ME, MN, NJ, NM, NY and VT).	Policy series 4000, 4002, 4006, 4008, 4040, 4042 & 4043	1993 - 1997	In 2005: • 12% - 40% increase for series 4000, 4002, 4040, 4042, &/or 4043 except in: ▪ LA, MI, NV & SC where increase range was 39%-56%; ▪ NC where increase range was 27% - 47% ▪ VA where increase range was 88% - 110% • 27% - 47% increase for series 4006 & 4008

However, please note that John Hancock has not raised it rates for this or any other John Hancock individual long-term care insurance policy it has sold in this or any other state.

Questions Related to Your Income

How will you pay each year's premium? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

❑ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy I the premiums will be more than 7% of your income.

Long-Term Care Insurance Personal Worksheet *(continued)*

Applicant A

Will you buy inflation protection? (check one) ❑ Yes ❑ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

The national average annual cost of care in 2004 was $70,080, but this figure varies across the country. In ten years, the national average annual cost would be about $114,152 if costs increase 5% annually.

What elimination period are you considering? Number of days: ________________

Approximate cost: $________________ for that period of care

How are you planning to pay for your care during the elimination period? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

(Check one)

❑ The information provided in this worksheet accurately describes my financial situation.

or

❑ I choose not to complete the financial information in this worksheet.

(The box directly below this statement must be checked.)

❑ I acknowledge that John Hancock Life Insurance Company and/or its agent (below) have reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Applicant A's Signature ____________________________________ Date __/___/___

❑ I explained to the applicant the importance of completing this information.

Agent's Signature ______________________________________ Date __/___/___

Agents Printed Name ____

❑ My agent has advised me that this policy does not appear to be suitable for me. However, I still want John Hancock Life Insurance Company to consider my application.

Applicant A's Signature ____________________________________ Date __/___/___

A Company representative may contact you to verify your answers.

Long-Term Care Insurance Personal Worksheet

Applicant B

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

The purpose of this worksheet is to help you and us decide if you should buy this policy.

Premium Information

Policy Form Number: ______________________________

The premium for the coverage you are considering will be $________ per ___________.

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums: John Hancock Life Insurance Company has a right to increase premiums on this policy form in the future, provided we raise rates for all policies in the same class in this state.

Rate Increase History

John Hancock has sold individual long-term care insurance since 1987 and has sold this John Hancock policy since 2006.

In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company block of individual long-term care insurance. John Hancock raised the premiums rates on the Fortis policy series listed below:

States	Fortis Policy Series	Years Fortis Policy Series was Available for Purchase	Fortis Policy Series Rate History
CA, FL, IL, IA, KS, KY, MO, NE, ND, OH, SD & TX.	Policy series 4040, 4042 & 4043; With associated riders 2020, 2021, 2022 & 2023 (where applicable)	1993 - 1997	30% increase in 2003
All states (except AK, DC, HI, ID, IA, KS, MA, ME, MN, NJ, NM, NY and VT).	Policy series 4000, 4002, 4006, 4008, 4040, 4042 & 4043	1993 - 1997	In 2005: • 12% - 40% increase for series 4000, 4002, 4040, 4042, &/or 4043 except in: ▪ LA, MI, NV & SC where increase range was 39%-56%; ▪ NC where increase range was 27% - 47% ▪ VA where increase range was 88% - 110% • 27% - 47% increase for series 4006 & 4008

However, please note that John Hancock has not raised it rates for this or any other John Hancock individual long-term care insurance policy it has sold in this or any other state.

Questions Related to Your Income

How will you pay each year's premium? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

❑ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy I the premiums will be more than 7% of your income.

Long-Term Care Insurance Personal Worksheet *(continued)*

Applicant B

Will you buy inflation protection? (check one) ❑ Yes ❑ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

The national average annual cost of care in 2004 was $70,080, but this figure varies across the country. In ten years, the national average annual cost would be about $114,152 if costs increase 5% annually.

What elimination period are you considering? Number of days: _________________

Approximate cost: $________________ for that period of care

How are you planning to pay for your care during the elimination period? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

(Check one)

❑ The information provided in this worksheet accurately describes my financial situation.

or

❑ I choose not to complete the financial information in this worksheet.

(The box directly below this statement must be checked.)

❑ I acknowledge that John Hancock Life Insurance Company and/or its agent (below) have reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Applicant A's Signature ______________________________________ Date __/___/___

❑ I explained to the applicant the importance of completing this information.

Agent's Signature ____ Date __/___/___

Agents Printed Name ____

❑ My agent has advised me that this policy does not appear to be suitable for me. However, I still want John Hancock Life Insurance Company to consider my application.

Applicant A's Signature ______________________________________ Date __/___/___

A Company representative may contact you to verify your answers.

John Hancock Life Insurance Company

John Hancock

Before You Buy

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Applicant(s) Copy

Disclosure Statement

Long Term Care Insurance Disclosure Statement
Policy Series LTC-06 NY & SG-06 NY

John Hancock Life Insurance Company
[LTC Administrative Office
333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203]

CAUTION: The issuance of this long term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: John Hancock Life Insurance Company, [LTC Administrative Office, 333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203 or call Us at 1-800-377-7311.]

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long term care incurred by You during the period of coverage. You are advised to review carefully all Policy limitations.

1. This Policy is an individual policy of insurance issued in the State if New York.
2. **PURPOSE OF DISCLOSURE STATEMENT.** This Disclosure Statement provides a very brief description of the important features of this Policy. You should compare this Disclosure Statement to disclosure statements for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!
3. **FEDERAL TAX CONSEQUENCES:** This Policy is intended to be a qualified long term care contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   Long term care insurance was granted favorable federal income tax treatment in the Health Insurance Portability and Accountability Act of 1996. Policies meeting certain criteria outlined in this Act are eligible for this treatment. To the best of Our knowledge, We have designed this Policy to meet the requirements of this law. If, in the future, it is determined that this Policy does not meet these requirements, We will make every reasonable effort to amend the Policy if We are required to do so in order to gain such favorable federal income tax treatment. We will offer you an opportunity to receive these amendments.
4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**

   (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   (b) **WAIVER OF PREMIUM.** We will waive the payment of premiums under this Policy if You are receiving services for which benefits are payable under the Long Term Care Benefit. The waiver period will start the day after You have satisfied 100 Dates of Service and will end on the date when benefits are no longer payable. The premium will not be waived, however, if benefits are only being received under the Additional Stay at Home Benefit.
5. **<u>TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS</u>. We reserve the right to increase Your premium as of any premium due date; however, any changes in premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a policy similar to Yours.**

6. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUMS REFUNDED**

(a) **THIRTY DAY FREE LOOK.** If You are not completely satisfied with this Policy for any reason, You may return it within 30 days from the date it was delivered to You. We will then refund any premium paid, and the Policy will be treated as if it had never been issued.

(b) **REFUND OF UNEARNED PREMIUMS.** Upon receipt of notice that You have died, We will refund the premium paid for any period beyond the date of death.

7. **THIS IS NOT A MEDICARE SUPPLEMENT POLICY**

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from John Hancock. Neither John Hancock Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. **LONG TERM CARE COVERAGE**

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the home.

This Policy provides coverage for actual charges incurred for care up to the applicable Benefit Amount for covered long term care expenses, subject to Policy limitations and requirements.

9. **BENEFITS PROVIDED BY THIS POLICY**

Benefit Limits Selected:	**Applicant A**	**Applicant B**
• [Long Term Care Benefit Amount • <u>Monthly Benefit</u> $3,100 to $15,500 in $100 increments (Metropolitan area) $2,200 to $15,500 in $100 increments (non-Metropolitan area) • *<u>Daily Benefit</u>* $100 - $500 in $100 increments (Metropolitan area) $70 to $500 in $100 increments (non-Metropolitan area)	$__________	$__________
• Benefit Period 3-year, 5-year or 5-year Plus* * The 5 Plus option is a 5-year Benefit Period plus the $1Million Rider	__________	__________
• Elimination Period	100 Dates of Service	100 Dates of Service
• Automatic Inflation Coverage	Included	Included
• Optional Benefits Selected:		
• SharedCare	__________	__________
• 0-Day Elimination Period for Home Health Care & Adult Day Care	__________	__________
• Nonforfeiture	__________	__________]

Important Note: You may choose either a monthly or daily Long Term Care Benefit Amount. This choice is important as other Policy benefits are dependent upon this choice. We will provide You with information on how a choice of a monthly or daily Long Term Care Benefit Amount will impact Policy benefits.

(a) **Long Term Care Benefit.** Subject to Policy requirements and limitations, this Policy provides coverage for actual charges up to the Long Term Care Benefit Amount incurred by:

- Your confinement in a Nursing Home or Assisted Living Facility for Your room, board and care services (such care services being Nursing Care, Custodial Care and Hospice Care);
- Home Health Care (including homemaker services), Hospice Care, Respite Care; or
- attendance at an Adult Day Care Center providing Adult Day Care.

Please note the following:

- The Elimination Period shall not apply to Hospice Care. During Your Elimination Period, actual charges incurred for Hospice Care up to the Long Term Care Benefit Amount are payable under the terms of this Policy.
- The Elimination Period shall not apply to Respite Care. During Your Elimination Period, actual charges incurred for Respite Care are payable up to the Respite Care Benefit Amount per day for up to 21-days in any Policy Year subject to the terms of this Policy. The Respite Care Benefit Amount is equal to 1/30th of the Long Term Care Benefit Amount if the monthly option is chosen, or the Long Term Care Benefit Amount if the daily option is chosen. Please note that after Your Elimination Period has been satisfied, We will pay the actual charges incurred for Respite Care up to the Long Term Care Benefit Amount.
- If Your stay in a Nursing Home or Assisted Living Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence.

We will not pay benefits for charges during the Elimination Period, except for Hospice Care, Respite Care and the Additional Stay at Home Benefit. Elimination Period (waiting period) means the number of Dates of Service that would otherwise be covered by this Policy, for which We will not pay benefits. Only one complete Elimination Period needs to be satisfied while Your Policy is in force. The Elimination Period starts on the first Date of Service. No Date of Service may be counted as more than one day towards the satisfaction of Your Elimination Period. The Dates of Service used to satisfy Your Elimination Period do not need to be consecutive and may be accumulated under separate claims. Days that You only receive Hospice Care, Respite Care or the Additional Stay at Home Benefit will not count toward the satisfaction of Your Elimination Period.

(b) **Care Coordination**: Care Coordination provides You with an important and valuable resource. The Care Coordination Benefit provides You and Your family members with access to the services of a Care Coordinator who is also a Licensed Health Care Practitioner. The Care Coordinator will assess Your needs for long term care, develop a written Plan of Care designed to meet those needs, and help You and Your family to navigate through the long term care delivery system; and may assist in the coordination and the monitoring of long term care services as appropriate. In addition, using the Care Coordination Benefit will help You minimize the paperwork by streamlining the claim process.

The entire cost of the services provided by the Care Coordinator is paid by Us and will *not* count against Your Policy Limit. In addition, the Elimination Period does *not* have to be met in order for You to receive Care Coordination services. *Please note that use of the Care Coordination is entirely voluntary.*

When You choose to access the Care Coordination Benefit, the Care Coordinator may provide You with the following services:

- *Assessment and Certification*. The Care Coordinator will conduct an assessment to determine Your status and needs. The assessment encompasses a wide range of factors that make Your situation unique, such as Your functional, cognitive, behavioral, and emotional well-being, as well as family support and the safety of Your environment. This assessment of Your needs will form the basis of the Care Coordinator's Certification that You are a Chronically Ill Individual and Your Plan of Care.

- *Development of Your Plan of Care.* The Care Coordinator will work with You, Your Physician, Your family or Your representative, to develop a Plan of Care. This is a collaborative process. The Plan of Care will describe the type and frequency of services that will meet Your needs as identified in the assessment.

- *Coordinating Service Delivery.* The Care Coordinator may assist You in securing the services recommended in Your Plan of Care as necessary. The Care Coordinator will provide You with information on provider resources local to You, community programs, and health information resources.

- *Monitoring.* After You begin to receive services through Your Plan of Care, We will periodically check with You, Your family and Your providers to: re-assess Your current condition; monitor and assess the care You are receiving; determine whether Your Plan of Care continues to be appropriate; and recommend any necessary changes. This re-assessment will occur at least once a year (or more frequently as We determine appropriate) in order to provide You with the required annual Certification and to update Your Plan of Care as needed.

If You choose not to access the Care Coordination Benefit or are receiving care or services outside the United States and its possessions, You must arrange for Your Physician or another Licensed Health Care Practitioner to certify that You are a Chronically Ill Individual and prepare a Plan of Care for You at Your own expense. You must submit all Certifications and Plans of Care to Us. Please see the Claims section of the Policy for more details.

(c) **Additional Benefits**.

- **Additional Stay at Home Benefit.** The Additional Stay at Home Benefit can be used to pay for a variety of Your long term care expenses while You are living in Your Home that are not otherwise covered under the Policy. Additional Stay at Home Services include:

  1. Home Modifications;
  2. Emergency Medical Response Systems;
  3. Durable Medical Equipment;
  4. Caregiver Training; and
  5. Home Safety Check.

  The Additional Stay at Home Lifetime Benefit Amount is equal to 1 times the Long Term Care Benefit Amount if the monthly option is chosen or 30-times the Long Term Care Benefit Amount if the daily option is chosen. Benefits paid under the Additional Stay at Home Benefit will reduce the Policy Limit. You do not have to satisfy the Elimination Period to receive benefits under the Additional Stay at Home Benefit. The days for which You receive only the Additional Stay at Home Benefit do not count toward the Elimination Period. You may receive benefits under the Long Term Care Benefit and/or Care Advisory Services Benefit while receiving benefits under the Additional Stay at Home Benefit.

(d) **Eligibility for Payment of Benefits**. You are eligible for benefits under this Policy if You are a Chronically Ill Individual. A Chronically Ill Individual means that You:

- are unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living due to the loss of functional capacity for a period expected to last 90 days; or
- require Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

Activities of Daily Living mean the following activities: bathing, continence, dressing, eating, toileting, and transferring.

Cognitive Impairment means a deficiency in a person's short-term or long term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(e) **Conditions.** To receive benefits under this Policy, You must:

- Your Elimination Period must have been satisfied unless otherwise provided in this Policy;
- You must receive covered care or services while this Policy is in effect or You qualify for Extension of Benefits;
- You must receive care or services that are consistent with Your care needs and are covered under this Policy, and specified in the Plan of Care; and
- We must receive a current Plan of Care and written Proof of Loss, both of which are acceptable to Us.

Because this Policy is intended to be tax-qualified under federal law, You must ALSO provide Us with a written Certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual. The Certification must be renewed and submitted to Us every 12 months.

(f) **Optional Benefits**. You may elect any of the optional benefits listed. You must pay an additional premium for any of the optional benefits elected.

- **[SharedCare**. The SharedCare Rider allows Your Partner to access benefits under Your Policy if Your Partner first exhausts the available benefits payable under his or her policy. You and Your Partner may both receive benefits under Your Policy at the same time. In no event will We pay benefits that exceed the maximum Policy Limits of both policies combined. Your Partner must also have added an identical SharedCare Benefit Rider to his/her policy naming You as Covered Person for that policy. Your Partner only has access to Your Policy Limit less the following dollar amount – the sum of 365-days or 12-months, as the case may be, multiplied by Your Long-Term Care Benefit Amount. This means that this amount remains available for Your exclusive use while Your Policy is in force.

- **0-Day Elimination Period for Home Health Care and Adult Day Care**. We will waive the requirement that you satisfy the Elimination Period if You are receiving Home Health Care or Adult Day Care. The Elimination Period must still be satisfied before benefits are payable under Long Term Care Benefit for confinement in a Nursing Home or an Assisted Living Facility. However, days which the Home Health Care Elimination Period is waived will count toward meeting the facility Elimination Period.

- **Nonforfeiture Benefit.** If Your Policy lapses because You have not paid the premium within the Grace Period, after being in force at least three years (or one-year if You elect a limited pay option), it will remain in force with a reduced policy limit equal to the sum of the premiums You have paid.]

10. LIMITATIONS AND EXCLUSIONS

In addition to the Conditions to qualify for benefits set forth above, the following limitations and exclusions apply to the Policy.

(a) **Exclusions.** This Policy does not cover care, treatment or charges:

- for intentionally self-inflicted injury.
- required as a result of alcoholism or drug addiction (unless drug addiction was a result of the administration of drugs as part of treatment by a Physician).
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- due to participation in a felony, riot or insurrection.
- normally not made in the absence of insurance.
- provided by a member of Your Immediate Family, unless:
  - the family member is one of the following professionals -- a duly licensed registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed social worker, or registered dietitian; and
  - the family member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Center or organization which is providing the services;
  - the organization receives the payment for the services; and
  - the family member receives no compensation other than the normal compensation for employees in his or her job category.
- provided outside the fifty United States and its possessions except as described in the International Coverage section of this Policy.

(b) **Non-Duplication of Benefits**. This Policy will only pay covered charges in excess of charges covered under any of the following:

- Medicare (including amounts that would be reimbursed by Medicare but for the application of a Medicare deductible or coinsurance amounts).
- any other governmental program (except Medicaid).
- any state or federal workers' compensation, employer's liability or occupational disease law, or any mandatory motor vehicle no-fault law.

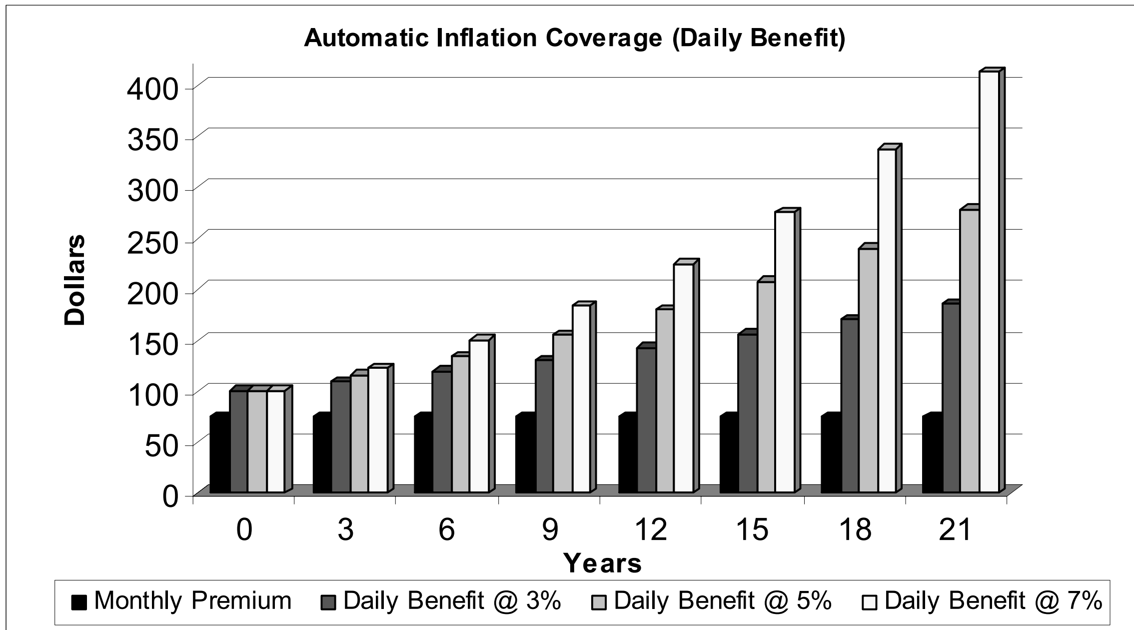
(b) **Charges not Covered.** We will not pay for any of the following: Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; durable medical equipment (except as described in the Additional Stay at Home Benefit); transportation; items and services furnished at Your request for beautification, comfort, convenience or entertainment; room and board charges for independent living quarters in a Continuing Care Retirement Community or similar entity; any type of residential upkeep, construction, renovation, or home maintenance (such as painting or plumbing); lawn/yard care; snow removal; or vehicle or equipment upkeep; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

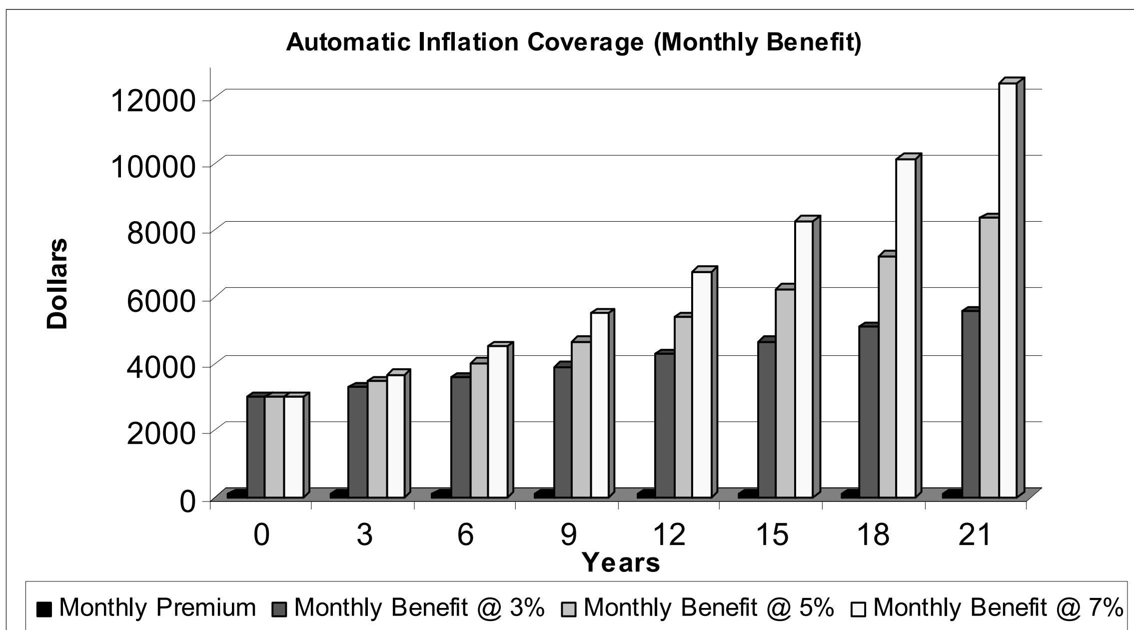
THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS**

Because the costs of long term care services will likely increase over time, Automatic Inflation Coverage is included in the Policy. Under Automatic Inflation Coverage, Your Long Term Care Benefit Amount will be increased on each Policy anniversary by the percentage change in the non-seasonally adjusted Consumer Price Index (CPI) three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long Term Care Benefit Amount. The premium for the Automatic Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under three possible scenarios – increases in coverage assuming a constant 3%, 5% or 7% change in the CPI. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long Term Care Benefit Amount of $3,100 or daily Long Term Care Benefit Amount of $100, and a 3-year Benefit Period.





12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

We cover brain disorders with demonstrable organic cause (including Alzheimer's Disease and similar forms of senility and irreversible dementia) that result in a Cognitive Impairment which are diagnosed by a Physician after the Effective Date of Coverage.

13. **PREMIUMS**

The total premium for Your Policy as well as a breakdown of the premium by base policy/optional benefits are found below.

Annual Premium:	Applicant A	Applicant B
Base Policy (includes Automatic Inflation Coverage)	$____________	$____________
• Optional Benefits Selected:		
• SharedCare	$____________	$____________
• 0-Day Elimination Period for Home Health Care & Adult Day Care	$____________	$____________
• Nonforfeiture	$____________	$____________
Total Annual Premium	$____________	$____________
	Your premium will be $ _______ on a ___________ basis.**	Your premium will be $ _______ on a __________ basis.**]

** You may elect to pay Your premium on an annual, semi-annual, quarterly or monthly basis. Please note that the more often you pay, the higher your premium amount will be per year. Additional premium charges are included for semi-annual, quarterly, and monthly premiums. These charges are called "modal fees". These fees are based upon the following modal factors and are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, .52 for semi-annual, .2625 for quarterly and .0875 for monthly. To calculate Your approximate total annual premium payment based on Your current policy selection:

- Multiply the "Total Annual Premium" as shown in the box above by the factor associated with Your selected mode of payment, and then
- Multiply that result by the number of payments required in a year based upon Your selected payment mode.

14. **ADDITIONAL FEATURES**

(a) Issuance of Your coverage may depend upon certain medical information about You. This is generally known as medical underwriting.

(b) This Policy provides added protection against lapse. You may name another person on the application to receive a termination notice 30 days after the premium due date. If Your Policy terminates because You did not pay a premium while You would meet the eligibility requirements for the payment of benefits, it may be reinstated within 5 months of the date of termination if: You give Us proof of the Cognitive Impairment or Your inability to perform 2 of the Activities of Daily Living without Substantial Assistance; and You pay all the unpaid overdue premiums.

(c) This Policy includes an International Coverage Benefit. The International Coverage Benefit provides that we will pay actual charges incurred for covered Long Term Care Services up to the International Coverage Benefit for care received outside the United States. The International Coverage Benefit will not be paid in excess of an amount equal to: 365-times the Long Term Care Benefit Amount if You elected the daily Benefit Amount option; or 12-times the Long Term Care Benefit if You elected the monthly Benefit Amount option.

(d) The expected benefit ratio for this policy is 60% for issue ages up to 65 and 65% for issue age 65 and older. This ratio is the portion of future premiums, which we expect to return as benefits, when average over all people with this policy.

15. **CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY OR CERTIFICATE.**

NOTICE OF INFORMATION PRACTICES

Thank you for applying to John Hancock. As part of our normal underwriting procedure, we need to obtain information to determine eligibility for coverage. Much of that information will come from you, but we often obtain additional information or verify information through other sources.

In order to evaluate your application fairly, we may consult various sources. These include:

- statements you make on your application;
- reports from doctors or medical facilities;
- employers
- other insurance companies
- consumer reporting agencies;
- the Medical Information Bureau, Inc. (MIB).

A consumer report may be obtained through personal interviews with your neighbors, friends, or others whom you know. It may include information on your character, reputation, and lifestyle, except as related directly or indirectly to sexual orientation. You may request to be interviewed in connection with the preparation of the consumer report. Additional information about the nature and scope of such a report will be furnished to you upon written request made within a reasonable time after you receive this notice. If we did request a consumer report on you, we will give you the name, address and telephone number of the consumer reporting agency involved within 5 business days of your written request to the designated address.

You should know that the content of a report prepared for us by an outside agency may be kept by that agency and disclosed to others who request its services. You may receive a copy of the report from the consumer-reporting agency if you request it and give proper identification.

WE WILL TREAT THIS INFORMATION AS CONFIDENTIAL. It will not be released without your authorization except as necessary to conduct our business. For example, we may disclose information:

- to your doctor if there is a condition of which you may not be aware;
- to John Hancock employees, reinsurers or affiliates when needed to handle your insurance or as required by law;
- to law enforcement agencies when illegal activities are suspected;
- to an insurance regulatory authority;
- a research or actuarial organization;
- in coded form to the Medical Information Bureau. This is an information exchange operated by member companies. Such information may be given to another member when you apply for life or health insurance.

YOU HAVE ACCESS TO YOUR RECORDS. Upon your request, the Medical Information Bureau will arrange for you to learn what is in your file and how any information may be corrected. You may contact them at PO Box 105, Essex Station, Boston, MA 02112, (617) 426-3660. Medical information will be disclosed only through your doctor.

You may also request access to any recorded personal information we may have about you that is reasonably locatable. If you make a written request, we will, within thirty (30) days of the day we receive your request:

- inform you of the nature and substance of the recorded personal information; and
- permit you to see and copy in person the personal information, or if you prefer, receive a written copy by mail; and
- report to you the identity, if recorded, of those persons to whom we have disclosed the personal information within the two (2) years prior to the request. If there are no disclosures recorded, you will be informed of the persons to whom such information is normally disclosed.

CORRECTION OF INFORMATION. If you believe any of our information is incorrect, please notify us and explain why you believe it is inaccurate or incomplete. We will review it.

If we agree with you, we will correct the information and notify any person designated by you to whom we have disclosed the information within the preceding two years.

If we disagree with you, we will tell you that we will not make the requested change. Then you may submit to us information and your reasons for disagreeing with our decision not to change the information. We will then furnish your statement to any person designated by you to whom we have disclosed the information in the prior two years. We will include your statement with our information in future disclosures.

ADDITIONAL INFORMATION: We hope this information enables you to understand how and why we obtain information about you and how we use that information. If you have questions about our information practices, send them to:

John Hancock Life Insurance Company
LTC Underwriting
John Hancock Place
PO Box 111
Boston, MA 02117

John Hancock Life Insurance Company

Notice of Protected Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We Respect Our Customers' Privacy

Respect for our customers' privacy, especially with regard to medical information, has long been highly valued at John Hancock. The trust of our customers is our most valuable asset, and the reason we are in business. We understand that the proper handling of medical information is critical to earning that trust.

We collect medical information from long-term care and medical insurance customers, and sometimes from their medical providers, to make decisions about issuing coverage, charging premiums, and paying claims. This notice will describe how we may use and disclose this medical information.

We are providing you with this notice in accordance with federal health privacy regulations that were issued as a result of the Health Insurance Portability and Accountability Act ("HIPAA"). We have obligations under that law to maintain the privacy of your medical information, which we take very seriously. We are required to:

- provide you with notice of our legal duties and privacy practices regarding your medical information. This notice is to satisfy this duty.
- provide you with a paper copy of this notice upon your request, even if you received it electronically.
- comply with the terms of our privacy notice that is in effect. We reserve the right to change this notice, and such change will apply to all medical information that we maintain. If we make a material change to this notice, we will promptly send a revised notice to all long-term care and medical insurance clients.

It is possible that you have received or will receive additional privacy notices from us. Those notices are provided in accordance with other laws and regulations, and describe our practices with respect to personal and financial information in addition to medical information.

Use And Disclosure Of Your Medical Information

Below is a description of ways in which insurance companies, including John Hancock, are permitted to use and disclose the medical information we receive about you in connection with a long-term care or medical insurance application or policy. The uses and disclosures described below, and those that are incidental to such uses and disclosures, are permitted without a signed authorization from you. We will not use your medical information for any other purpose, or disclose it to any other person, unless we have your signed, written authorization to do so.

Use and disclosure for payment related purposes. We are permitted to use and disclose your medical information for our payment related purposes or those of another insurer, health plan, or health care professional. Examples of our payment related purposes include obtaining premiums, providing reimbursement for health care, or determining or fulfilling our responsibility for coverage and benefits under your insurance policy or certificate.

For example, if you have a John Hancock long-term care insurance policy and present a claim for benefits, we may obtain medical records from your doctor to determine if you are eligible for benefits under the terms of the policy.

Among the payment-related uses and disclosures that are permitted are:

- determining eligibility for coverage,
- making claim decisions,
- care coordination activities,
- coordinating benefits with other insurers or payers,
- billing,
- claims management,
- collection activities,
- collecting reinsurance, and
- related health care data processing.

We may also disclose your name, address, date of birth, social security number, payment history, account number, and the name and address of your health care provider(s) and/or health plan to consumer reporting agencies in connection with collection of premiums or reimbursement.

Use and disclosure for health insurance operations. We are also permitted to use and disclose your medical information for purposes related to our health insurance operations, or the health insurance operations of another insurer or health plan with which you have coverage or have applied for coverage. Our health insurance operations may include underwriting, premium rating, and other activities related to the issuance, renewal or replacement of a long-term care or medical insurance policy or certificate, or for reinsurance purposes.

For example, when you apply for insurance, we may collect medical information from your doctor to determine if you qualify for insurance.

We may also use and disclose such information:

- to conduct or arrange for medical review, legal services, or auditing, including fraud and abuse detection and compliance programs;
- for business planning and development, such as administration, development or improvement of methods of payment or coverage procedures;
- for business management and general administrative activities such as those that relate to compliance with HIPAA; customer service; providing data analyses for policyholders, plan sponsors or other customers (without disclosing the medical information to them); resolving internal grievances; sale, merger, transfer, or similar activities; or removing identifiers from medical information; or
- to offer an enhancement to or upgrade of your existing coverage.

If you are insured under a group long-term care insurance policy, we may also disclose your medical information to the sponsor of your benefit plan to report claims experience or for audit purposes.

Use and disclosure for public health, government, or similar activities. We are permitted to disclose your medical information as described below, although we anticipate any such disclosure to be quite rare:

- to an authorized public health authority or cooperating foreign government official for public health purposes;
- to a public health or other appropriate government authority authorized to receive reports of child abuse or neglect;
- to a person subject to the jurisdiction of the Food and Drug Administration for purposes related to the quality, safety or effectiveness of FDA-regulated products or activities;
- if authorized by law, to a person who may have been exposed to or at risk of contracting a communicable disease or condition;
- to a government authority when there is reason to suspect abuse, neglect, or domestic violence;
- to a health oversight agency for authorized oversight activities; and
- to a coroner or medical examiner, a funeral director, or for organ or tissue donation purposes.

We may also use or disclose your medical information for judicial or administrative proceedings or for law enforcement purposes; for research purposes; to avert a serious threat to health or safety; for specialized government functions; or for workers' compensation or similar purposes.

Disclosure to you, your family, and to health care professionals. If you send us a written request, we will disclose your medical information that we have to you.

We may disclose your medical information to your family member, friend, personal representative, or other individual you identify who is involved in your care or reimbursement for your care, but we will first give you an opportunity to give or withhold your consent, where possible. If you are not available to give your consent to such a disclosure, or in an emergency, we may disclose your medical information that is directly relevant to such person's involvement with your care or payment for such care.

We may also disclose your medical information for the treatment activities of a doctor or other health care professional.

Your Authorization To Use and Disclose Medical Information

We are not permitted to, and will not, use or disclose your medical information in any way that is not mentioned above, unless we have your signed, written authorization to do so. You have the right to revoke in writing at any time an authorization you give to us, but not if we have acted in reliance on the authorization, nor if you provided the authorization in order to obtain your insurance coverage.

Your Rights Regarding Your Medical Information

You have certain rights concerning the medical information we have about you in our records, as described below.

Request Restrictions. You have the right to request that we restrict our use and disclosure of your medical information that otherwise would be permitted for purposes related to payment or our health insurance operations, or to your family, friends or others involved in your care or reimbursement for your care.

We are not required to agree to such a restriction, and a restriction will not apply to disclosures to you or for certain public health or government purposes. If we agree to such a restriction, we will not use or disclose your medical information in violation of it except if you need emergency treatment, in which case we will request that your medical provider not further use or disclose it.

We may terminate the restriction upon your written request or with your agreement, or at our initiative, but only as it affects medical information created or received after we advise you of the termination.

Inspect and Copy. You have the right to inspect and obtain a copy of your medical information maintained in our records, but not psychotherapy notes nor information we compile in anticipation of a claim or legal proceeding.

To make a request, please submit it in writing to the address at the end of this notice. If you would like to specify a particular form or format for the information, we will try to accommodate your request if it can readily be produced in that manner; otherwise, we will provide a paper copy or other form or format that we agree upon. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent.

We have a right to decline your request in limited situations, such as where a doctor or other health care professional has determined that substantial harm could be caused to you or another person by giving your medical information to you. In that situation, you would be given a right to have any such denials reviewed by a health care professional designated by us. In the unlikely event that we decline your request, we will give you a written explanation, and advise you of your rights to pursue a review of our decision.

If we do not maintain the medical information that you request, we will tell you where it is if we know. We will respond to your request for access within 30 days after receiving your request, unless the information is not on our premises or we tell you in writing why we need more time, in which case we will respond within 60 days.

Confidential Communications. You have the right to request that we send your medical information to you at a different location or by a means other than mail.

Any such request should be sent to us in writing to the address at the end of this notice, and should specify an alternative address or other means of contacting you.

Amend. You have the right to request that we amend your medical information in our records if you believe that it is inaccurate or incomplete. To make such a request, please submit it in writing to the address at the end of this notice, giving details of your request and why you are making it. We will respond to your request within 30 days.

If we accept your request, we will amend all appropriate records, and take steps to notify appropriate persons you identify as well as persons we know to have the erroneous medical information.

We may deny your request in certain circumstances, such as if the medical information or record you wish to be amended is accurate and complete, or it was not created by John Hancock (unless the creator is no longer available), or it relates to an anticipated claim or legal proceeding. In that case, we will tell you in writing why we declined your request, and describe your rights, which include (a) the right to submit a written statement of disagreement (subject to our right to prepare a rebuttal statement that we will give to you), which will become part of our records, and will be

included with or summarized for future disclosures of the medical information, (b) the right to request that we provide your request for amendment and our denial with any future disclosures of the medical information, and (c) the right to file a complaint.

Accounting. You have the right to request an accounting of disclosures we made of your medical information, subject to certain exceptions.

To make such a request, please submit it in writing to the address at the end of this notice. We will respond within 60 days unless we tell you in writing why we need more time, in which case we will respond within 90 days.

Contacting Us

We appreciate the value you place on your privacy rights. We want to hear from you if you have any concerns about John Hancock's commitment to protecting your privacy rights.

To make a request as described in the section entitled "Your Rights Regarding Your Medical Information," please send your request in writing to: John Hancock Life Insurance Company, John Hancock Place, P.O. Box 111 Boston, MA 02117, Attention: Customer Relations X-5.

Be sure to include the following information in your request:

- your full name,
- address,
- date of birth, and
- policy number.

If you believe that your privacy rights have been violated and wish to make a complaint, you may send a written complaint including specific details to the address above. You may also submit a complaint to the United States Secretary of Health and Human Services. You can be assured that you will not be retaliated against by John Hancock if you file a complaint.

For further information regarding this notice or John Hancock's privacy practices, please call our dedicated privacy line at **1-800-550-3787**, Monday through Friday, between the hours of 9 a.m. and 5 p.m. (ET). If you have any product or customer service questions, including those about your policy, please call the Customer Service number listed on your policy or recent statement.

Effective September 30, 2002

John Hancock Life Insurance Company, Boston, Massachusetts 02117
OCP1000 RLTC
Edition 11/02

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about long-term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.