



# New Business Transmittal John Hancock Life Insurance Company of New York

Transmittal Date

### Mailing Address

Attn: New Business Service Center  
John Hancock Life Insurance Company of New York  
PO Box 55765  
Boston MA 02205-5765

### Overnight Courier

Attn: New Business Service Center  
John Hancock Life Insurance Company of New York  
27 Drydock Ave  
Boston MA 02210-2377

Firm  Formal  Informal Query (IQT)

New Business Firm Contact	New Business Firm Contact	Phone Number	Fax Number
	E-mail Address	Street Address	
	Is this a Wholesaling case? <input type="checkbox"/> No <input type="checkbox"/> Yes	Broker Dealer	

Producer	Producer Name - First and Last		
	SSN	John Hancock Producer Code	
	In relation to this insurance application, can we contact the Producer directly? <input type="checkbox"/> No <input type="checkbox"/> Yes	Phone Number	Fax Number

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

Proposed Insured	Proposed Insured (1) Name	Proposed Insured (2) Name	
	In relation to this insurance application, can we contact the Proposed Insured directly? <input type="checkbox"/> No <input type="checkbox"/> Yes	Phone Number	Best time to call

### Attachments – Mark ( x )

- |  |  |                             |
|--|--|-----------------------------|
| <input type="checkbox"/> Authorization           | <input type="checkbox"/> Temporary Insurance Agreement         | <b>Medical Requirements</b> |
| <input type="checkbox"/> Cover Letter            | <input type="checkbox"/> Premium Check                         |                             |
| <input type="checkbox"/> Non-Med                 | <input type="checkbox"/> Certified TIN                         |                             |
| <input type="checkbox"/> Avocation Questionnaire | <input type="checkbox"/> Trust Document                        |                             |
| <input type="checkbox"/> Signed Proposal         | <input type="checkbox"/> Fund Allocation or Policy Detail Form |                             |
| <input type="checkbox"/> Replacement Forms       | <input type="checkbox"/> Other (Specifics)                     |                             |
| <input type="checkbox"/> 1035 Forms              | _____  |                             |

### Outstanding Requirements – Mark items already ordered with ( x ) and indicate the Service Provider.

- |  |  |                                      |                         |
|--|--|--------------------------------------|-------------------------|
| <input type="checkbox"/> Authorization           | <input type="checkbox"/> Temporary Insurance Agreement         | <b>Medical Requirements</b>          | <b>Service Provider</b> |
| <input type="checkbox"/> Cover Letter            | <input type="checkbox"/> Premium Check                         | <input type="checkbox"/> Para-Med    | _____                   |
| <input type="checkbox"/> Non-Med                 | <input type="checkbox"/> Certified TIN                         | <input type="checkbox"/> Blood/micro | _____                   |
| <input type="checkbox"/> Avocation Questionnaire | <input type="checkbox"/> Trust Document                        | <input type="checkbox"/> EKG/TST     | _____                   |
| <input type="checkbox"/> Signed Proposal         | <input type="checkbox"/> Fund Allocation or Policy Detail Form | <input type="checkbox"/> X-Ray       | _____                   |
| <input type="checkbox"/> Replacement Forms       | <input type="checkbox"/> Other (Specifics)                     | <input type="checkbox"/> APS         | _____                   |
| <input type="checkbox"/> 1035 Forms              | _____  |                                      |                         |

John Hancock's Regional Director Name

Comments/Special Handling Instructions



# LifeCare Ticket

John Hancock Life Insurance Company of New York  
(hereinafter referred to as The Company)

Print and use black ink.

## PROPOSED LIFE INSURED

1. a) Name \_\_\_\_\_  
First Middle Last
- b) Date of Birth \_\_\_\_\_  
month day year
- c) Social Security Number (SSN) \_\_\_\_\_
- d) Sex  Male  Female
- e) Primary Residence \_\_\_\_\_  
Address - Street No. & Name Apt. No. City State Zip Code

## CONTACT INFORMATION

Provide the most convenient time to be contacted.

2. a) Primary Telephone No. \_\_\_\_\_ b) Secondary Telephone No. \_\_\_\_\_
- c) Best time to call  Morning  Afternoon  Evening

## BENEFICIARY INFORMATION

3. a) Beneficiary \_\_\_\_\_  Primary \_\_\_\_\_ %  
First Middle Last Relationship to Proposed Life Insured Percentage
- b) Beneficiary \_\_\_\_\_  Primary \_\_\_\_\_ %  
 Secondary \_\_\_\_\_ %  
First Middle Last Relationship to Proposed Life Insured Percentage

## POLICY DETAILS

4. a) Face Amount \$ \_\_\_\_\_ b) Single Premium \$ \_\_\_\_\_
- c) Acceleration Benefit Period (for long term care services)  
 2 Years  3 Years
- d) Optional Rider  Accelerated Death Benefit (for terminal illness)

## EXISTING INSURANCE AND REPLACEMENT INFORMATION

5. a) Is this insurance to replace, or will it cause a change in, or involve a loan under, any insurance or annuity policy on any Proposed Life Insured's life or in any insurance or annuity policy owned by the Owner?  
 Yes  No If 'Yes', please complete the state appropriate replacement forms.
- b) Does the Owner intend to replace any long term care, medical or health coverage with the coverage applied for?  
 Yes  No If 'Yes', please complete the  
**Notice for Replacement of Individual Accident and Sickness or Long Term Care Insurance, NB5019NY.**
- c) Is this a 1035 Exchange?  Yes  No If 'Yes', please complete and submit 1035 Exchange forms.

## SPECIAL REQUESTS

6. \_\_\_\_\_

## AGENT/REGISTERED REPRESENTATIVE INFORMATION

7.	Name of Agent/Registered Representative	Agent Code	Social Security No.	Telephone No.	E-mail Address	% Share

8. BGA/Firm/Agency Name \_\_\_\_\_

9. Broker Dealer/Wholesaler (if applicable) \_\_\_\_\_

## SOLICITATION INFORMATION

- This business was solicited in the state of \_\_\_\_\_.
- I have met with my client.
- My client has answered the pre-screening questions and to the best of my knowledge is eligible for LifeCare.
- I will provide the Proposed Owner with the Outline of Coverage, Buyer's Guide, Notice of Disclosure of Information and an Illustration.

Signature of Agent/Registered Representative \_\_\_\_\_ Signed this \_\_\_\_\_ Day of \_\_\_\_\_ Year \_\_\_\_\_

X \_\_\_\_\_



## LifeCare Pre-Qualifying Questionnaire For Agent Use

In order to successfully submit a ticket for LifeCare coverage, all of the following requirements must be met.

**This form is for your use as you determine your client's eligibility for LifeCare; it does not need to be submitted to John Hancock.**

- ✓ **PRE-QUALIFYING HEALTH QUESTIONS**      Your client must be able to answer **No** to all of the questions in the Pre-Qualifying Health Questions section that follows below.
- ✓ **EXISTING COVERAGE**                      Your client does not currently have a John Hancock life policy with a long term care (LTC) rider or an existing LifeCare policy.
- ✓ **LANGUAGE**                                      Your client is fluent in the English language.
- ✓ **RESIDENCY**                                      Your client is a permanent resident of the United States.
- ✓ **MEETING**                                        You have met personally (face-to-face) with your client to discuss this product.

### PRE-QUALIFYING HEALTH QUESTIONS \*

	Yes	No
1. Has your client previously been declined for long term care (LTC) insurance or life insurance by John Hancock or any other carrier?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your client ever been diagnosed with:		
a) Alzheimer's disease, dementia, or any other cognitive impairment including memory loss – whether treated or untreated?	<input type="checkbox"/>	<input type="checkbox"/>
b) Parkinson's disease, multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease), or Huntington's disease?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your client have:		
a) moderate to severe emphysema, chronic obstructive pulmonary disease (COPD), chronic lung disease, or congestive heart failure; and/or does your client use oxygen for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
b) a chronic kidney disease, are they on dialysis, or are they the recipient of an organ transplant of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
c) rheumatoid arthritis, or joint pain treated with Methotrexate, Arava, Enbrel or Remicade?	<input type="checkbox"/>	<input type="checkbox"/>
d) osteoporosis that is untreated, a history of compression fractures, or does the client have any paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
e) cancer, or has cancer been diagnosed within the past 12 months (other than non-melanoma skin cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
4. a) Has your client had a stroke anytime in the past, or within the past 6 months, has the client had a transient ischemic attack (TIA), heart attack (MI, myocardial infarction), heart or carotid surgery?	<input type="checkbox"/>	<input type="checkbox"/>
b) Does your client have an implantable defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your client:		
a) unable to independently perform any of the activities of daily living (i.e. eating, bathing, continence, dressing, transferring, toileting, or walking)?	<input type="checkbox"/>	<input type="checkbox"/>
b) attending or has attended adult day care, or been confined to a nursing home in the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
c) using any type of assistance with mobility, such as a cane, walker, wheelchair or motorized scooter?	<input type="checkbox"/>	<input type="checkbox"/>
d) currently collecting, or have they applied for disability benefits of any kind; or are they eligible for Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>

\*If your client has any pending investigative tests, then you should wait until they have been performed and the results communicated to him or her. If the client is awaiting surgery or has been advised to have surgery, do not submit a ticket until at least 3 months after the surgery has been completed, and the client is fully recovered with no remaining physical limitations from the original condition or the procedure itself.

An affirmative answer to any of the following conditions may not necessarily constitute uninsurability for John Hancock's fully underwritten products. If any of these questions are answered **Yes**, please speak with your sales support office for information on other John Hancock products that are available.

For Broker Dealer Use Only

Insurance products are issued by: John Hancock Life Insurance Company (U.S.A.) (not licensed in New York), Boston, MA 02116 and John Hancock Life Insurance Company of New York, Valhalla, NY 10595.

NB5132US (03/2010)

(NF)

VERSION (03/2010)



LIFE INSURANCE

# LifeCare Personal History Worksheet for Proposed Life Insured

A worksheet to help you prepare for your personal history telephone interview. This form does not need to be submitted to John Hancock.

Thank you for your interest in John Hancock's LifeCare product. For the next step in the process, a nurse will call you to gather information needed to complete the application.

Specifically, a nurse will contact you to ask you questions about your:

- Medical history and any medications you currently take
- Habits such as drinking, smoking, etc.
- Hobbies, e.g., sports activities, travel, volunteer work, etc.
- Usual daily activities, e.g., how you handle meal preparation, shopping etc.

The entire interview should take approximately 40-45 minutes.

Although the majority of questions can be answered without preparation, several require very specific information that would best be gathered prior to the interview. Therefore, to ensure a faster, easier interview we are providing this worksheet for you to gather some of the vital information the nurse will collect during the call. In addition, please review the authorization at the end of this document (see Appendix A), which will be read to you during your interview.

### How to Use this Worksheet

- Complete as much of information as possible in the spaces provided below. You may want to check your financial records and/or call your physician to obtain accurate information.
- Use the additional space on the last page for any information that doesn't fit within the space provided.
- Keep the worksheet handy to use as a reference during the interview with the nurse.

### A - Personal Information

Please have your Social Security Number handy for verification purposes.

### B - Existing Life Insurance

Please list details of existing **life** insurance and **long term care** policies you have in force and any pending applications not yet approved or issued.

	Company Name	Type of Insurance	Amount of Coverage	Issue/Applied Date
1				
2				
3				
4				
5				

### C - Medication

Record all medications you currently take including **prescription medication, over the counter drugs, vitamins, and herbal supplements.**

	Name of Drug	Dosage	Frequency	Reason for Taking
1				
2				
3				
4				
5				

## D - Cholesterol and Blood Pressure History

Please record your most recent cholesterol and blood pressure below.

### Cholesterol

Most Recent Cholesterol Reading
Most Recent HDL
Date

### Blood Pressure

	Most recent blood pressure readings	Date(s)
a		
b		
c		

## E - Medical History

Please provide details of any health conditions you have been diagnosed with, treated for or are currently being treated for.

**Note: For any history of cancer, coronary heart disease, diabetes, lung disease and osteoporosis please also supply the additional details listed in section F as applicable.**

1	Name of Condition	Date of Diagnosis	Symptoms	Date of Last Visit to Doctor

Treating Physician's Name and Address
---------------------------------------

	Treatment	Date
a		
b		
c		

	Tests	Results	Date
a			
b			
c			

2	Name of Condition	Date of Diagnosis	Symptoms	Date of Last Visit to Doctor

Treating Physician's Name and Address
---------------------------------------

	Treatment	Date
a		
b		
c		

	Tests	Results	Date
a			
b			
c			

## F - Condition Details

Please provide these additional details for any applicable condition listed below.

### Coronary Heart Disease History, if applicable

<b>1</b>	Type of Event	Date(s)	Details, if applicable
	a Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No		
	b Bypass Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of vessels
	c Angioplasty <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of vessels
		Date of most recent test	Results
	d Treadmill Stress Test		
<b>e</b>	Other Heart Studies	Type of test	Results
		Date of most recent test	Ejection Fraction if known

### Osteoporosis, if applicable

<b>2</b>	Details		
	T-Score/Bone Density	Any Height Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how much?
		Any fractures? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many? Where?
		Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	What do you do? How often?

### Diabetes, if applicable

<b>3</b>	Tests	Date(s)	Results
	Age at Diagnosis	Last Fasting Blood Sugar	
	Treatment	Last Hemoglobin A1C (HgA1C)	
	Complications: Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No    Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No    Nephropathy <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other			

### Lung Disorders, if applicable

<b>4</b>	Type of Disorder	Treatment)	Frequency of Attacks/Infections
	a Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No		
	b Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Yes <input type="checkbox"/> No		
	c Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No		
	d Pulmonary Function Test Results		Date
	e Dates of hospitalization or ER visits		

## F - Condition Details - continued

### Cancer History, if applicable

5		Type of Cancer	Treatment and Dates of Treatment	Classification	Lymph Node Involvement?	Any Recurrence?
a	Breast			Size of Tumor Stage/Grade	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date
b	Colon			Dukes Staging	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date
c	Melanoma			Clark level/Stage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date
d	Prostate			Gleason Score Stage Current PSA	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date
e	Other			Stage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Date

### Please list all physicians including any specialists not already listed in section F.

6		Name	Street Address, City, State, Zip Code	Reason Seen/Condition	Date
a					
b					
c					
d					
e					

## G - Additional Information

Please use this space for any additional details.

Topic	Details
a	
b	
c	
d	
e	
f	
g	
h	

Thanks for taking the time to complete this information. It is our hope that by preparing in this way, your interview call will be as quick and easy as possible. If you have any questions, please contact your Representative.

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## Appendix A

During your application interview you will be read the following statement. Please take a moment to review prior to the interview call and/or use it to follow along as it is read to you.

### **HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) VOICE AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION**

Do you authorize any pharmacy, pharmacy benefit manager or any other similar provider that has provided payment, treatment or services to you or on your behalf within the past 10 years to disclose your entire prescription history and medications prescribed to you and any consumer reporting agency such as MIB, Inc. having protected health information about you to disclose it to John Hancock Life Insurance Company (U.S.A.), which will hereafter be referred to as The Company. (Please answer Yes or No.)

By answering Yes, you acknowledge that any agreements you have made to restrict your protected health information do not apply to this Authorization. Further, you authorize the disclosure of protected health information to The Company's affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as the MIB.

By answering Yes, you authorize The Company to use the protected health information disclosed under this Authorization to underwrite your application for life and/or long term care insurance, make eligibility, risk rating, policy issuance and enrollment determinations, obtain reinsurance, administer claims and coverage, and conduct other legally permissible activities.

This Authorization shall remain in force for 24 months following the date of your voice Authorization. You have the right to revoke this Authorization in writing, at any time, by providing written notification to the Company.

By answering Yes, you understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about you or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. If any of your protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

You further understand that if you refuse to provide this Authorization, The Company may not be able to process your application.

Do you understand and accept all of the terms and conditions of this Authorization as of today? (Please answer Yes or No.)

\*Please mail your request to John Hancock, Underwriting Dept. C5, 197 Clarendon St., Boston, MA 02117.



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

**Notice of Disclosure of Information**  
**John Hancock Life Insurance Company of New York**  
 (hereinafter referred to as The Company)

Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s).

**PROPOSED LIFE INSURED(S)**

**LIFE ONE**

1. Name

\_\_\_\_\_  
 First Middle Last

**LIFE TWO**

2. Name

\_\_\_\_\_  
 First Middle Last

**INFORMATION EXCHANGE**

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

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

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

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

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

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

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

Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**INVESTIGATIVE CONSUMER REPORT NOTICE**

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

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

**INSURANCE INFORMATION PRACTICES**

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

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

**Please provide each Proposed Life Insured with a copy.**



Life Insurance Company of New York

Customer Service Center R02,  
1 John Hancock Way, Suite 1350, Boston,  
Massachusetts, 02217-1099

**ACCELERATION OF LIFE INSURANCE BENEFIT FOR QUALIFIED  
LONG TERM CARE SERVICES RIDER -- FORM 09WLLTCR  
OUTLINE OF COVERAGE**

**CAUTION.** The issuance of this rider is based upon our issuance of the policy and the responses to the questions on the application for this rider. A copy of the application for the policy and the application for this rider are attached to the policy. If the responses to the questions on the application for this rider are not complete, true, and correctly recorded or fail to include all material information requested, the Company has the right (in addition to any rescission rights described in the policy) to deny benefits or rescind the rider subject to the Time Limit on Certain Defenses/Incontestability provision. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the answers are incorrect, contact the Company at this address: John Hancock Life Insurance Company of New York, Customer Service Center R02, 1 John Hancock Way, Suite 1350, Boston, Massachusetts, 02217-1099, or call us at 1-800-267-7781.

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

1. This rider is attached to an individual life insurance policy issued in the state of New York.

**2. PURPOSE OF OUTLINE OF COVERAGE:**

This Outline of Coverage provides a very brief description of the important features of the rider. The Owner and the Life Insured should compare this Outline of Coverage to outlines of coverage for other policies or riders available to the Life Insured. This is not an insurance contract, but only a summary of coverage. Only the life insurance policy and rider contain governing contractual provisions. This means that the life insurance policy and rider set forth in detail the rights and obligations of you, the Life Insured, and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY AND RIDER CAREFULLY!

**3. FEDERAL INCOME TAX TREATMENT OF THE RIDER:**

This rider is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code ("Code") of 1986, as amended.

Long term care insurance was granted favorable federal income tax treatment by the Health Insurance Portability and Accountability Act of 1996 ("Act"). Policies meeting certain criteria outlined in this Act are eligible for this treatment. The benefits provided by the policy are intended to be excludable from federal gross income under Code section 7702B, as may be amended from time to time. If, in the future, it is determined that this rider does not meet these requirements, we will make reasonable efforts to amend the rider if we are required to do so in order to comply. We will offer you an opportunity to receive these amendments. Premium for this rider may be a distribution for income tax purposes. If you have any questions concerning the tax implications of this rider, you should consult with an attorney or qualified tax advisor.

**IMPORTANT NEW YORK NOTICE:**

**This is not a health insurance rider and is not subject to the minimum requirements of New York Law pertaining to Long Term Care Insurance and does not qualify for the New York State Long Term Care Partnership Program and is not a Medicare Supplement Policy. The rider is intended to be a qualified long term care insurance contract for federal tax law only.**

**4. TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED:**

**RENEWABILITY: THIS RIDER IS NONCANCELLABLE.** This means that subject to the terms of the policy and rider, this rider will continue as long as the rider premium is paid when due. In addition, we cannot change any of the terms of the rider without consent and cannot change the rider premium.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE THE RIDER PREMIUM**

We do not have the right to increase the rider premium.

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED AND RIDER PREMIUM REVERSED**

- (a) THIRTY DAY FREE LOOK. If you or the Life Insured are not completely satisfied with the rider for any reason, you or the Life Insured may return it within 30 days from the date it was delivered. We will then reverse any long term care rider premium imposed, and the rider will be treated as if it had never been issued.
- (b) Refund of Unearned Rider Premiums. As the policy and rider are paid by a single premium and are considered fully paid up, the rider does not provide for a refund or partial refund of premium upon the death of the Life Insured or upon termination of the rider.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

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

8. **LONG TERM CARE COVERAGE**

Policies and riders 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.

The rider provides accelerated benefits for actual charges incurred for care up to the Maximum Monthly Benefit Amount for covered long term care expenses, subject to rider limitations and requirements.

9. **LONG TERM CARE ACCELERATED BENEFITS PROVIDED BY THE RIDER**

(a) Covered Services

Subject to the conditions, limitations, and exclusions found in the rider, we will make a monthly Accelerated Benefit payment in an amount not to exceed the lesser of (i) the charges incurred by the Life Insured for Qualified Long Term Care Services, and (ii) the Maximum Monthly Benefit Amount. The monthly benefit will be payable provided we have received evidence satisfactory to us that the Life Insured has incurred charges for Qualified Long Term Care benefits, as described below.

The monthly benefit payment is based upon Qualified Long Term Care Services received in a Calendar Month time period and the Accelerated Benefit we have approved for that period.

A portion of each approved monthly benefit amount will be used to repay a portion of any Policy Debt under the policy and will reduce the monthly benefit payment for that period.

(b) Qualified Long Term Care Benefits

Subject to the conditions, limitations, and exclusions described in the rider, we will make a payment of Accelerated Benefits in an amount not to exceed the lesser of:

- (1) the charges incurred by the Life Insured for Qualified Long Term Care Services; and
- (2) the Maximum Monthly Benefit Amount.

Payment of Accelerated Benefits is conditioned upon our receiving evidence satisfactory to us that the Life Insured is:

- (i) confined in a Nursing Home or an Assisted Living Facility for room, board, and care services (such care services being Nursing Care, Custodial Care, and Hospice Care); or
- (ii) receiving Home Health Care, Hospice Care, or Respite Care ; or
- (iii) attending an Adult Day Care Center providing Adult Day Care.

(c) Eligibility for Payment of Benefits

Accelerated Benefit payments may be made under the rider if the Life Insured is a Chronically Ill Individual.

Activities of Daily Living mean the following activities: Bathing, Continenence, Dressing, Eating, Toileting, and Transferring.

Chronically Ill Individual means that the Life Insured:

- (i) is unable to perform without Substantial Assistance from another individual, as certified in writing by a Licensed Health Care Practitioner, at least two of the Activities of Daily Living due to the loss of functional capacity for a period expected to last 90 days; OR
- (ii) requires Substantial Supervision, as certified to in writing by a Licensed Health Care Practitioner, to protect him or herself from threats to health and safety due to the presence of a Cognitive Impairment.

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.

(d) Conditions to receive benefits under this rider

- the 90-day Elimination Period has been satisfied;
- the Life Insured is receiving Qualified Long Term Care Services that are consistent with the Life Insured's care needs and are covered under this rider and such services are specified in a Plan of Care;
- there is a current Plan of Care and written Proof of Loss for the Life Insured, both of which are acceptable to us. (Plan of Care and written Proof of Loss must be renewed and submitted to us every 12 months, otherwise benefit payments under this rider will discontinue on the first day following the end of the 12 month period.); and
- we determine that the Life Insured is eligible for benefits under this rider.

Because this rider 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 meet the definition of a Chronically Ill Individual. The certification must be renewed and submitted to us every 12 months.

## 10. **LIMITATIONS AND EXCLUSIONS**

In addition to the conditions set forth above, the following limitations and exclusions apply to the rider.

(a) Exclusions. Qualified Long Term Care Services do not cover care or treatment:

- 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.
- for which no charge is normally made in the absence of insurance.
- provided by a member of the Life Insured's 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 dietician; and
  - the family member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Care Center or organization which is providing the services; and
  - 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 District of Columbia except as described in the International Coverage Benefit provision of the rider.

- (b) Non-Duplication of Benefits. Qualified Long Term Care Services do not include charges covered under any of the following:
- Medicare (including amounts that would be reimbursable but for the application of a 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.
- (c) Limitations-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; transportation; items and services furnished for beautification, comfort, convenience, or entertainment of the Life Insured, 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; vehicle or equipment upkeep; and charges for care or services which are not included in and/or are inconsistent with the Life Insured's Plan of Care.

**THE RIDER 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, you and the Life Insured should consider whether and how the benefits of this rider should be used. ***This rider does not include inflation protection coverage.*** Increases and decreases to the Insurance Benefit of the policy resulting from the exercise of the rights thereunder, including the right to make policy loans and partial surrenders, will cause a change in the Maximum Monthly Benefit Amount and the amount payable upon the Life Insured's death.

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

This rider covers charges for services necessitated by brain disorders with demonstrable organic cause (including Alzheimer's Disease and similar forms of senility and irreversible dementia) that result in the Life Insured's Cognitive Impairment.

**13. LONG TERM CARE RIDER PREMIUM**

The rider premium for the long term care rider is shown in the Policy Specifications page for this rider.

**14. ADDITIONAL FEATURES; REINSTATEMENT**

- (a) Issuance of this coverage may depend upon certain medical information about the Life Insured. This is generally known as medical underwriting.
- (b) This rider provides added protection against termination. If this rider lapses, this rider and policy may be reinstated if requested within 5 months of the date of termination, and if the following conditions are met:
- we are furnished with satisfactory proof that you were unable to perform at least two of the Activities of Daily Living, or had a Cognitive Impairment on the date of termination; and
  - you pay all amounts overdue as stated in the underlying policy.

All rights under this rider will be the same as they were just before the rider terminated.

- (c) Effect on the Life Insurance Policy and Rider.

This rider interacts with the life insurance policy to which it is attached. Each rider benefit payment reduces the benefits and values under the life insurance policy. Once benefits are paid under this rider, you and the Life Insured will receive a monthly statement showing the amount of benefits paid and the effect of such payments on the policy insurance benefits and cash values, as well as the maximum rider benefits available. Benefits under this rider affect the life insurance policy as follows.

- Partial Surrenders and Terminal Illness Accelerated Benefit. Any partial surrender or acceleration of the Insurance Benefit due to Terminal Illness, including those made during a Period of Care under this rider, reduces the Maximum Monthly Benefit Amount, resulting in a new Maximum Monthly Benefit Amount, as determined by us. Such reduction will be effective as of the effective date of the partial surrender or acceleration of the Insurance Benefit.
- Insurance Benefit and Face Amount. Each monthly benefit payment reduces the current Face Amount, resulting in a new Face Amount.
- Cash Value. Each Accelerated Benefit amount reduces the current Cash Value, resulting in a new Cash Value.
- Loans. Prior to payment of a monthly Accelerated Benefit payment, a portion of the payment will be used to repay part of any loans under the policy, thus reducing the amount available for long term care expenses.

(d) This rider includes an International Coverage Benefit.

The International Coverage Benefit provides that we will pay the actual charges incurred by the Life Insured for covered Qualified Long Term Care Services up to the Maximum Monthly Benefit Amount for care received outside the United States. The Benefit Period applicable to the International Coverage Benefit is limited to 12 times the Maximum Monthly Benefit Amount.

**15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU OR THE LIFE INSURED HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR ACCELERATED BENEFIT RIDER.**



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

**EXTERNAL 1035 Exchange**  
**Absolute Assignment/Beneficiary Change**  
**John Hancock Life Insurance Company of New York**  
(hereinafter referred to as The Company)

**EXISTING POLICY(IES)**  
**PROPOSED LIFE INSURED(S)**

**LIFE ONE**

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

**LIFE TWO**

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

3. Existing Policy(ies) issued by \_\_\_\_\_  
Company Name

**Complete one form per Issuing Company and Owner.**

**Confirm original policy has been lost or destroyed. If trust owned, provide full name of trust and name(s) of trustee(s), including date of trust.**

Proposed Life Insured		Policy Number	Policy Lost or Destroyed		Owner	Is there a loan on the existing policy?		If 'Yes' do you wish to transfer the loan?	
Life One	Life Two		Yes	No		Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**EXCHANGES TO NEW POLICY**

WHEREAS the undersigned desires to exchange the above referenced Existing Policy(ies) under Section 1035 of the Internal Revenue Code, NOW THEREFORE, in consideration for The Company agreeing to issue a new policy (the "New Policy") in exchange for the Existing Policy(ies),

1. Upon final approval of the undersigned's application for the New Policy, the undersigned:
  - a) Assigns and transfers absolutely all right, title and interest in the above referenced Existing Policy(ies) to:  
 John Hancock Life Insurance Company of New York  
 PO Box 55765  
 Boston MA 02205-5765  
 Attention: LIFE NEW BUSINESS
  - b) Authorizes The Company to file this Absolute Assignment / Beneficiary Change with the Existing Insurer, and do everything that is required to accomplish the surrender of the Existing Policy(ies) for the cash surrender value.
  - c) Names The Company as beneficiary under the Existing Policy(ies), revoking any prior beneficiary designations.

If a proposed life insured dies prior to the final approval of the undersigned's application for the New Policy, this Absolute Assignment / Beneficiary Change is void and of no effect.

2. The undersigned warrants that each Existing Policy is free and clear of any liens or prior assignments and is not subject to any bankruptcy or collection proceedings.
3. The undersigned understands and agrees that:
  - a) Coverage under the New Policy shall not become effective until the later of the date the first premium has been paid in full and the date the New Policy has been delivered, subject to all of the terms and conditions of the New Policy.
  - b) If the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the assignment of the above referenced Existing Policy(ies) to The Company according to this Absolute Assignment / Beneficiary Change, The Company will pay a death benefit to the beneficiary named in the application for the New Policy equal to the lesser of (i) the amount of insurance applied for under the New Policy, or (ii) the total amount of death proceeds that would have been payable under the above referenced Existing Policy(ies), subject to all of the terms and conditions of the Existing Policy(ies). If the Existing Insurer rescinds any of the above referenced Existing Policy(ies) or otherwise dishonors this Absolute Assignment / Beneficiary Change or the Company's surrender request with respect to any Existing Policy(ies), the amount of death proceeds that would have been payable under such Existing Policy(ies) will not be included in the calculation of the total amount of death proceeds set forth in (ii) above.
  - c) If the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the assignment of the above referenced Existing Policy(ies) to The Company, any amounts paid by the Existing Insurer under the Existing Policy(ies) to a claimant other than The Company shall be deducted from the amount owed to the beneficiary named in the application for the New Policy under the provisions set forth in paragraph b) above.

**EXCHANGES TO NEW POLICY continued**

4. The undersigned is responsible for and agrees to pay any and all premium payments that may come due prior to the assignment of the Existing Policy(ies), which is effective upon final approval of the undersigned's application for the New Policy, in accordance with the terms of such Existing Policy(ies).
5. The undersigned agrees that notwithstanding this Absolute Assignment / Beneficiary Change, the Existing Insurer shall be responsible for: 1) the failure to properly calculate the values of the Existing Policy(ies); 2) the delay or failure in paying surrender values to The Company; and 3) the failure or delay in providing to The Company the accurate cost basis, Modified Endowment Contract ("MEC") status, and income tax gain information on the Existing Policy(ies). The Company shall have no obligation or liability relating to or arising from these responsibilities.
6. The undersigned understands and agrees that at any time prior to the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer requesting the surrender of the Existing Policy(ies) for the cash surrender value, The Company may release this Absolute Assignment / Beneficiary Change and reassign ownership of the Existing Policy(ies) to the undersigned.
7. If the undersigned should subsequently decide to cancel the application for the New Policy or return the New Policy under the "free look" provision, The Company will release this Absolute Assignment / Beneficiary Change. It is understood that in the event of the cancellation of the application or return of the New Policy under the "free look" provision, the undersigned may not be able to return the cash surrender proceeds to the Existing Insurer and/or reinstate the Existing Policy(ies) as most insurance policy contracts do not extend the right of reinstatement if a policy was surrendered. If The Company has already requested the surrender of any Existing Policy(ies), The Company's only obligation hereunder shall be the return of all premiums received. Such refund of premiums shall be paid, at the direction of the undersigned, either to the undersigned or to the Existing Insurer.
8. The Company is furnishing this form and is participating in this transaction at the undersigned's specific request, as an accommodation to the undersigned. The undersigned states and agrees that The Company makes no representations concerning the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise, and The Company has no responsibility or liability for the validity of this Absolute Assignment / Beneficiary Change nor the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise.
9. The undersigned understands that any outstanding loan(s) on any Existing Policy(ies) at the time of the assignment that is not transferred and applied to the New Policy may be reported to the Internal Revenue Service by the Existing Insurer as a distribution and will be taxable up to the amount of gain in such Existing Policy(ies) immediately prior to the assignment.

**SIGNATURES**

Signed at	City	State	This	Day of	Year
Signature of Agent/Registered Representative as Witness				Signature of Owner (if corporation, officer(s) and title(s) must be indicated)	
<b>X</b>				<b>X</b>	
				Signature of Owner (if corporation, officer(s) and title(s) must be indicated)	
				<b>X</b>	

**CONFIRMATION - FOR INTERNAL USE ONLY**

**Accepted by:** John Hancock Life Insurance Company of New York

This	Day of	Year	Signature of Company Official
			<b>X</b>



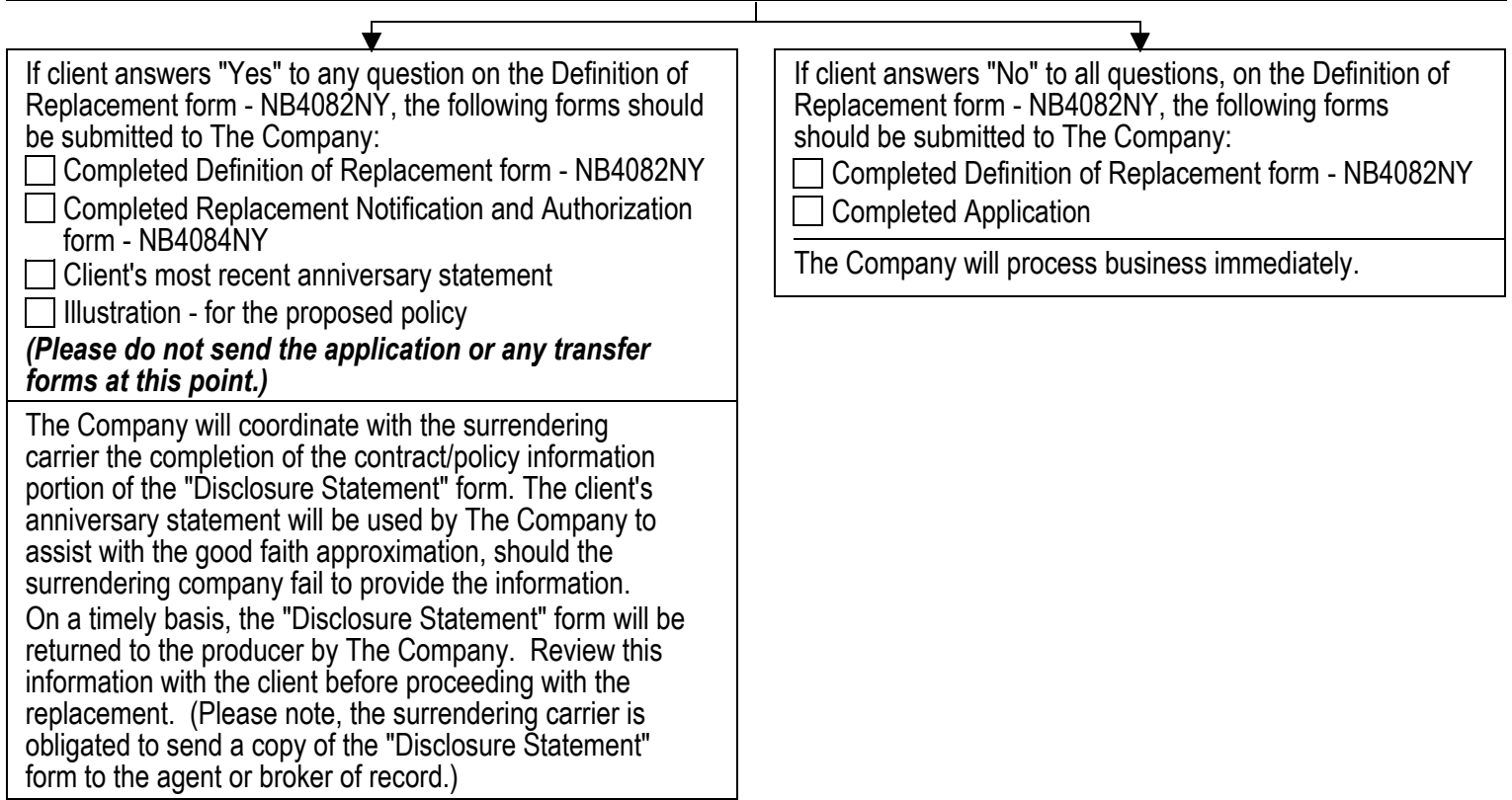
**Instructions to Comply with Regulation 60**  
**John Hancock Life Insurance Company of New York**  
*(hereinafter referred to as The Company)*

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

**DOING BUSINESS THE REGULATION 60 WAY... It's as easy as 1, 2, 3.**

Follow these simple instructions to comply with Regulation 60 when considering the purchase of a new policy.

**STEP 1**  
 COMPLETE DEFINITION OF REPLACEMENT FORM



**STEP 2**

To continue the replacement process, submit the following completed:

- Disclosure Statement: where applicable, complete either
  - Disclosure Statement for non-Term products - NB4080NY
  - Disclosure Statement for Term to Term (with no cash value) Only - NB4810NY
- Application
- Important Notice Regarding Replacement form - NB4081NY
- Sales Material and signed Illustration
- 1035 Exchange form (if applicable)

**STEP 3**

The Company receives and processes the replacement request.  
 Your client will receive a new policy once funds are received from the surrendering carrier.



Insurance Department of The State of New York - Definition of Replacement

John Hancock Life Insurance Company of New York

(hereinafter referred to as The Company)

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

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- (1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?
(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?
(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?
(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?
(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?
(6) CONTINUED AS A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: SIGNATURE OF APPLICANT:

DATE: SIGNATURE OF APPLICANT:

To the best of my knowledge, a replacement is involved in this transaction: Yes No

DATE: SIGNATURE OF AGENT OR BROKER:

CLIENT COPY



Insurance Department of The State of New York - Definition of Replacement

John Hancock Life Insurance Company of New York

(hereinafter referred to as The Company)

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

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

- (1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?
(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?
(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?
(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?
(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?
(6) CONTINUED AS A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE DEPARTMENT REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH A COMPLETED DISCLOSURE STATEMENT AND THE IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

DATE: SIGNATURE OF APPLICANT:

DATE: SIGNATURE OF APPLICANT:

To the best of my knowledge, a replacement is involved in this transaction: Yes No

DATE: SIGNATURE OF AGENT OR BROKER:

SERVICE CENTER COPY



**Replacement Notification and Authorization**  
**John Hancock Life Insurance Company of New York**  
*(hereinafter referred to as The Company)*

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

NAME OF APPLICANT(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

NAME OF AGENT OR BROKER: \_\_\_\_\_

BROKER DEALER FIRM OR GENERAL AGENCY: \_\_\_\_\_

AGENT'S OR BROKER'S ADDRESS: \_\_\_\_\_

AGENT'S OR BROKER'S PHONE NUMBER: \_\_\_\_\_

PRODUCT NAME: \_\_\_\_\_

**AUTHORIZATION:** By signing below, I authorize and request the above named agent or broker and The Company to obtain account information from my current insurer related to my existing life insurance policy or annuity contract.

CARRIER NAME

ADDRESS

POLICY NUMBER

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_