

**Essential Care II
Producer Application Instructions**

Please follow these instructions to ensure a smooth and timely application process. All state required disclosure information must be presented prior to the application. 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 client's to prepare them for the underwriting process.

Please use the Checklist below to ensure that required forms are presented, signed, dated and submitted if indicated.

✓	Form Name	Form #	Action
	Application	BSCAPP 03 MD	Applicant must sign and date page 6. Producer must sign and date page 7.
	HIPAA Medical Authorization	LTCMED-03 MD	MUST be signed and dated by applicant and submitted with application in order for the underwriting process to begin. We cannot accept an altered document.
	Advance Payment Receipt	LTCCR-03 MD	The amount of the initial deposit is to be recorded and the applicant and producer must sign and date. Submit one copy with the application. Provide one copy for the applicant.
	Replacement Form	15-LTC-03	Applicant and producer must sign (if replacing other LTC insurance). Submit one copy with the application. Provide one copy to the applicant.
	Suitability Personal Worksheet	LTC-PWK MD 9/03	Applicant and producer must complete, sign, date and submit with application.
	Suitability Information Sheet	LTC-SUIT 9/03	Provide a copy to the applicant.
	Outline of Coverage	OCBSC-03 MD	Prior to application provide a completed Outline to applicant. Sign and date any required forms.
	Notice of Insurance Practices	LTC-INF 10/00	Provide a copy to the applicant.
	Notice of Protected Health Information Privacy Practices	OCP1000 RLTC	Provide a copy to the applicant.
	Medicare Disclosure	LTC-96-Med 9/96	Provide a copy to the applicant.
	Potential Rate Increase Disclosure Form	LTC-RII MD 9/03	Provide a copy to the applicant.
	Buyer's Guides		
	NAIC LTC Shoppers Guide	LTC-1059	Provide a copy to the applicant.
	Guide to Medicare for People age 65 and older	LTC-1014	Provide a copy to the applicant.

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

Long-Term Care Insurance is underwritten by
John Hancock Life Insurance Company
Boston, MA 02117

Application

Control No: _____

For Individual Long-Term Care Insurance
John Hancock Life Insurance Company
Boston, MA 02117



Please note - any changes made to the application, other than dates or signatures, must be initialed by the applicant.

Part 1 – Personal Information

1a. Name (First, M.I., Last):			
1b. Street Address:			
City:	State:	Zip Code:	
1c. Payor Name (if different from above):			
Billing Address:	City:	State:	Zip Code:
1d. SS #:	1e. Birthdate (mm/dd/yyyy):	/	/
1f. Birth Place (State, Country)	1g. <input type="checkbox"/> Male	<input type="checkbox"/> Female	
1h. Height:	1i. Weight:		

Part 2 – Selection of Benefits

* Not available for ages 80 – 84.

2a. Nursing Home Daily Benefit Amount: \$ _____ \$50 - \$500 in \$10 increments (Limit of \$250 for ages 80-84)	
2b. Home Health Care Daily Benefit: <input type="checkbox"/> 100% of the Nursing Home Daily Benefit <input type="checkbox"/> 80% of the Nursing Home Daily Benefit <input type="checkbox"/> 50% of the Nursing Home Daily Benefit	
2c. Benefit Periods (Years): <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4* <input type="checkbox"/> 5* <input type="checkbox"/> 6* <input type="checkbox"/> 10* <input type="checkbox"/> Lifetime*	
2d. Elimination Period (Dates of Service): <input type="checkbox"/> 30* <input type="checkbox"/> 60* <input type="checkbox"/> 90 <input type="checkbox"/> 180 <input type="checkbox"/> 365	
2e. Benefit Increase Options: <input type="checkbox"/> None <input type="checkbox"/> Guaranteed Purchase Option <input type="checkbox"/> 5% Simple Inflation <input type="checkbox"/> 5% Compound Inflation (Benefit Amounts and Policy Limit increase at 5% compounded annually)	Please Note: If you elect: Compound Inflation; the 5% Simple Inflation option and/or a Limited Payment option, the Guaranteed Purchase Option is not available.
2f. Rejection of Inflation Protection: (Please read. You must check the box below if you do not select Compound Inflation.) <input type="checkbox"/> I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plan BSC-03 MD, and I reject inflation protection. Applicant's Signature: _____	
2f. Optional Benefits: <input type="checkbox"/> SharedCare* (Please complete question 4e. Not available with Lifetime Benefit Period.) <input type="checkbox"/> Nonforfeiture	
2g. Rejection of Nonforfeiture: (You must check the box below if you have not elected Nonforfeiture.) <input type="checkbox"/> Benefits and costs of the Nonforfeiture benefit have been explained to me and I do not want it included. Applicant's Signature: _____	

Part 3 – Should You Submit this Application?

YES	NO	Please check "YES" or "NO" beside each question. If "YES", circle all diagnoses or conditions that are applicable.
<input type="checkbox"/>	<input type="checkbox"/>	3a. Within the last 7 years, have you had a diagnosis for : • Alzheimer's • Amyotrophic Lateral Sclerosis • Cerebral Atrophy • Cirrhosis • Cystic Fibrosis • Crest • Dementia • Diabetes with insulin (regardless of units) • Kidney Failure • Memory Loss • Mental Retardation • Metastatic Cancer • Mixed Connective Tissue Disease • Multiple Sclerosis • Muscular Dystrophy • Neurological conditions affecting the brain or spinal cord • Multiple Myeloma • Organic Brain Syndrome • Parkinson's • Post Polio Paralytic Syndrome • Schizophrenia • Scleroderma • Spinal Cord Injury • Myasthenia Gravis • Stroke/CVA • TIAs (2 or more)?
<input type="checkbox"/>	<input type="checkbox"/>	3b. Do you require human assistance or supervision in any of the following activities: • eating • dressing • toileting • transferring from bed to chair • walking • maintaining continence • bathing?
<input type="checkbox"/>	<input type="checkbox"/>	3c. Do you currently reside in, have you been advised, within the past 7 years, 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?
<input type="checkbox"/>	<input type="checkbox"/>	3d. Do you currently use one of the following medical devices: • wheelchair • walker • hospital bed • quad cane • oxygen • stairlift • dialysis?
<input type="checkbox"/>	<input type="checkbox"/>	3e. Within the past 7 years, have you been diagnosed or treated by a member of the medical profession for: AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?
<input type="checkbox"/>	<input type="checkbox"/>	3f. Are you currently receiving Social Security disability benefits?

STOP! If you answered "YES" to any of questions 3a – 3f above, we suggest that you do not submit an application. We will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue.

Part 4 – Discounts, Family & Other Needed Information

You may be eligible for certain discounts. Please check "YES" or "NO" beside each numbered question or statement.

YES	NO	Marital Discount
<input type="checkbox"/>	<input type="checkbox"/>	4a. Are you married?
<input type="checkbox"/>	<input type="checkbox"/>	4b. Is your Spouse also applying for this insurance or does he/she currently have an existing John Hancock individual long-term care insurance policy? If 'YES', provide name, birthday and policy # (if available): _____
		Family Discount (Not available with the Sponsored Group Discount)
<input type="checkbox"/>	<input type="checkbox"/>	4c. Are you applying for a family discount? If YES, please list two other family members applying for, or who currently have, a John Hancock individual long-term care insurance policy and their relationship to you: Name: _____ Relationship: _____ Policy # (if available): _____
		Sponsored Group Discount (Not available with the Family Discount)
<input type="checkbox"/>	<input type="checkbox"/>	4d. Do you belong to a sponsored group? If YES, Sponsored Group #: (Please also provide proof of employment or membership with sponsored group.)
Optional Benefit Information – Only complete the questions below which are associated with the optional benefit you selected, if any.		
4e.		SharedCare – Please designate your spouse to be covered by this rider. _____

Part 5 – Insurance History

YES	NO	Please check "YES" or "NO" beside each numbered question or statement.			
<input type="checkbox"/>	<input type="checkbox"/>	5a. Are you covered by Medicaid? (If YES, list details):			
<input type="checkbox"/>	<input type="checkbox"/>	5b. Are you receiving any disability benefits?		Disability %:	
		If YES, Reason: _____			
<input type="checkbox"/>	<input type="checkbox"/>	5c. Have you had another long-term care insurance policy or certificate in force during the last 12 months? If 'YES', please provide details below.			
<input type="checkbox"/>	<input type="checkbox"/>	5d. Do you have another long-term care insurance policy or certificate in force (including a health care service, health maintenance organization or Medicare Supplement contract)? If 'YES', please provide details below.			
<input type="checkbox"/>	<input type="checkbox"/>	5e. Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying? If 'YES', please provide details below.			
Company	Policy/Cert.#	Annual Premium	Benefit Type & Amounts	Currently In Force?	Is it being Replaced?
Please complete questions 5f and 5g below, only if you answered "YES" to any of questions 5c through 5e above.					
<input type="checkbox"/>	<input type="checkbox"/>	5f. I have been made aware of and considered: the potential adverse consequences of changes in my age and health in purchasing new insurance; the possible tax-consequences as a result of replacement; our right to challenge a claim generally within 2 years from the date of issue; and whether my current coverage could be modified to meet my needs.			
<input type="checkbox"/>	<input type="checkbox"/>	5g. I have compared: the benefits and premium rates of my current long-term care or other health insurance policy to those of the long-term care policy for which I am applying; and the financial strength of my current insurance company with that of John Hancock.			

Part 6 – Payment & Administration

6a. **Payment Types.** You must choose **one** of the following options. Please check boxes as appropriate.

1. **Direct Bill**

Payment Frequency: Annually Semi-Annual Quarterly

2. **Monthly Bank Draft** (enter information in the spaces provided)

Insured's Name: _____ Bank Account #: _____

Account Type: Checking Savings Bank Name: _____

Bank Routing #: _____ Select Draft Day (1st - 28th): _____

Name(s) of Depositor(s): _____

Signature(s): _____

Please include a voided check. The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on the selected draft day requested above.

3. **List Billing** List Bill Group #: _____

6b. **Limited Pay Options**

10-Year Payment Option or Paid-Up at 65 Payment Option (not available if applicant is older than 55)

If you choose any Limited-Pay Option, then the Guaranteed Purchase Option will not be available to you.

6c. **Special Requests:**

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 subjects such person to criminal and civil penalties.

Part 7 – Medical History

YES	NO	Please check "YES" or "NO" beside each question. If "YES", circle all diagnoses or conditions that are applicable.
<input type="checkbox"/>	<input type="checkbox"/>	7a. Have you been seen by your primary care physician within the past 18 months? If yes, date seen: ____/____/____ Who is your primary care physician? (Please list name, address and telephone number.) _____
<input type="checkbox"/>	<input type="checkbox"/>	7b. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months? If "YES", Type: _____ Frequency: _____ Duration of use: _____
<input type="checkbox"/>	<input type="checkbox"/>	7c. Within the last 7 years, have you received medical advice, diagnosis or treatment or consulted with a member of the medical profession for any of the following conditions?
<input type="checkbox"/>	<input type="checkbox"/>	1. 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
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine & Pituitary Disorders: • Diabetes • Addison's • Pancreatitis • Cushing's
<input type="checkbox"/>	<input type="checkbox"/>	3. Cancers: • Leukemia • Lymphoma • Tumors • Melanoma • Squamous Cell • Sarcomas
<input type="checkbox"/>	<input type="checkbox"/>	4. Genitourinary Disorders: • Renal Insufficiency • Incontinence • Prostate Disorders • Bladder Disorders
<input type="checkbox"/>	<input type="checkbox"/>	5. Gastrointestinal Disorders: • Hepatitis • Ulcerative Colitis • Crohn's Disease • Liver Disorders
<input type="checkbox"/>	<input type="checkbox"/>	6. Neurological Disorders: • Mental Illness • Depression • Seizures • Tremors • Neuropathy • Syncope • Anxiety • Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	7. Blood Disorders: • Anemia • Polycythemia Vera • Thrombocytopenia • Hemochromatosis
<input type="checkbox"/>	<input type="checkbox"/>	8. Musculoskeletal Disorders: • Osteoporosis • Arthritis • Rheumatoid Arthritis • Osteoarthritis • Fractures • Fibromyalgia • Degenerative Joint Disease • Scoliosis • Spinal Stenosis • Lupus • Polymyalgia Rheumatica • Osteopenia
<input type="checkbox"/>	<input type="checkbox"/>	9. Respiratory Disorders: • Emphysema • Bronchitis • Asthma • Bronchiectasis • Asbestosis • Sarcoidosis • Chronic Obstructive Pulmonary Disease
<input type="checkbox"/>	<input type="checkbox"/>	10. Eye & Ear Disorders: • Macular Degeneration • Glaucoma • Retinitis Pigmentosa • Labrynthitis • Meniere's/Vertigo
<input type="checkbox"/>	<input type="checkbox"/>	11. Substance Abuse: • Alcoholism • Drug dependency • Illicit drug use
<input type="checkbox"/>	<input type="checkbox"/>	7d. Within the last 7 years (excluding childbirth without complications), have you ever been hospitalized or have you consulted, or been treated by, a member of the medical profession for any reason not stated above in Question 7c?
<input type="checkbox"/>	<input type="checkbox"/>	7e. Within the last 5 years has any surgery or tests been recommended that have not been performed?
<input type="checkbox"/>	<input type="checkbox"/>	7f. Do you require human assistance or supervision in any of the following activities? • Meal preparation • House cleaning • Shopping • Laundry • Transportation • Taking medications
<input type="checkbox"/>	<input type="checkbox"/>	7g. Within the last 7 years, have you had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated?
<input type="checkbox"/>	<input type="checkbox"/>	7h. Do any of your immediate family members (father, mother, brother, sister) have a history of: • Diabetes • Heart Disease • Stroke • Parkinson's • Alzheimer's • Dementia?

If you answered "YES" to any of questions 7c – 7h above, provide full details on the next page.

7i. Day Telephone: (____) _____ Ext. _____ Evening Telephone: (____) _____
Cell Telephone: (____) _____ Your E-Mail Address (optional): _____
Best Time to Call (3-hour intervals starting at): _____ Weekend Calls: YES NO

In some instances, you may be contacted by a nurse on John Hancock's behalf to review your medical history and information. This interview is not an examination. We merely ask you detailed medical questions to help us underwrite your application.

Part 7 – Medical History (continued)

7j. **MEDICAL HISTORY DETAILS --** If you answered "YES" to any of questions 7c – 7g on the prior page, provide full details here. Include only dates that are within the last 7 years.

Quest. #	Diagnosis, Disorder and/or Reason	Diagnosis Date	Treatment Dates	Include Name, Address , Telephone Number of Physician, Provider and/or Insurer (if applicable) and Explanation or Comments

7k. **MEDICATIONS –** List all prescription medications taken at any time over the past 12 months.

Medication	Dosage	Frequency	Reason Prescribed	Physician Name

7l. **FAMILY HISTORY DETAILS –** If you answered "YES" to question 7h, provide full details here.

Family Member <i>(Please indicate – mother, father, brother, sister)</i>	Diagnosis/Disorder	Diagnosis Date	Age at Onset

Part 8 – Protection Against Unintended Lapse

I understand that I have the right to designate 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. *(You must check off one box below.)*

8a. I elect to designate the person below to receive such notice.

8b. I elect **NOT** to designate any person to receive such notice.

Name (First, M.I., Last):	
Street:	Applicant's Signature
City, State & Zip Code:	

Part 9 – Agreement & Acknowledgment

I agree as follows: My statements and answers on this application are to the best of knowledge and belief, true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

I understand that in order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete. In addition, in order to complete the underwriting process, John Hancock may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, or other questionnaire or test. I understand that no agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, alter any receipt provision, or to waive or change any questions on this application.

I have made an advance payment with this application and have reviewed and understand the provisions of the Advance Payment Receipt. I understand that any change in my health status after the later of the following: the date of this application, or the date I complete any physical exams or tests required by John Hancock, will not affect the underwriting of my application. I understand that if my application is approved, my long-term care insurance policy will be issued and delivered to me.

Acknowledgments: I have received the policy 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 replacement is involved). If eligible for Medicare, I have received the "Guide to Health Insurance for People with Medicare".

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

I have reviewed this application including all elections and answers contained within. By my signature, I affirm all the elections and answers in this application.

Signed at: _____
City State Signature of Applicant Date

Part 10 – Producer/Agent’s Statement

Interview:

- The Applicant was interviewed by me in person or by telephone on this date. I certify that each applicable question was personally asked of the Applicant by me and that I have accurately recorded the information supplied by the Applicant. I know nothing affecting his/her insurability not stated herein.
- The Applicant was not interviewed by me in person or by telephone on this date.

Replacement:

To the best of my knowledge, replacement of other insurance is / is not involved in this transaction. Listed below are all other health insurance policies (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. To the best of my knowledge, I have included policies sold by other Producers/Agents as well.

Company	Type of Policy	Effective Date	In Force?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

Underwriting:

I have reviewed the Underwriting Guidelines and the information provided in this Application. The following risk class was quoted to the Applicant:

- Preferred Select Class I (25%) Class II (50%)

Signature of Licensed Agent: _____

Agent Name (Please print): _____ Date: _____

Credit for Application

Producer/Agent Name (Please print):	
Agency/Bank/Firm Name:	
Social Security #:	Tel. #:
Annual Premium: \$	Fax #:
JH Agency Code (if known):	Email:
Signator Career Only: Payroll Number: Contract Code:	Attach producer/agent's business card here
If more than one agent was involved in the sale, provide details here:	
Agent Name: _____ Percentage: _____ Agent SS#: _____ Agency/Firm: _____	
Agent Name: _____ Percentage: _____ Agent SS#: _____	
Home Office Only:	
Agent Name: _____ Percentage: _____ Agent SS#: _____ Agency/Firm: _____	

HIPAA Medical Authorization

John Hancock Life Insurance Company
Boston, MA 02117



This authorization is intended to comply with HIPAA. "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all the following information: *my medical records and medical history*; and other information that relates to:
 - the diagnosis of any physical or mental condition; or
 - the treatment or prognosis of any physical or mental condition,

whether such 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.

2. 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.
3. Health information about me may be disclosed to John Hancock and its affiliates; service providers; reinsurers; agents and representatives; and to any consumer reporting agency such as the MIB.
4. Health information about me may be used or disclosed: in connection with my application; to determine the premium for long term care insurance; to service my long term care insurance coverage; and to evaluate any 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, we may be obligated to disclose health information to government, regulatory and law enforcement entities.
5. John Hancock is authorized to disclose health information about me to my doctor or other individual as designated below. Please provide name, address and telephone number such individual or entity.

Name: _____ Phone No.: _____

Address: _____

6. I understand that:
 - If I do not sign this Authorization, John Hancock may: decline to issue long term care insurance coverage to me; decline to pay any claim for such benefits; and decline to provide health information about me to my doctor or the individual/entity that I have designated above.
 - This authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I understand that I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
 - My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health 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.
 - A copy of this Authorization is as valid as the original.
 - I will receive a copy of this authorization.
 - This Authorization expires 24 months from the date I sign it.

Printed Name

Date

Signature

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: _____

Advanced Payment Program

John Hancock Life Insurance Company
Boston, MA 02117

Received: \$ _____

Applicant Name: _____

Requirements:

- You must make your advance payment by check, payable to 'John Hancock Life Insurance Company'. 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's 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.

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. 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 within 30 days, without interest.

On behalf of John Hancock Life Insurance Company:

Agent Signature: _____

Applicant Signature: _____

Date: _____

Advanced Payment Program

John Hancock Life Insurance Company
Boston, MA 02117

Received: \$ _____

Applicant Name: _____

Requirements:

- You must make your advance payment by check, payable to 'John Hancock Life Insurance Company'. Do not make checks payable to the agent or leave the payee section blank.
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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 within 30 days, without interest.

On behalf of John Hancock Life Insurance Company:

Agent Signature: _____

Applicant Signature: _____

Date: _____

John Hancock Life Insurance Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application and information that you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by John Hancock Life Insurance Company. Your new policy provides thirty (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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT, BROKER OR OTHER REPRESENTATIVE I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, 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 the material medical information 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's Signature

Signature of Agent, Broker or Other Rep.

Print Name of Agent, Broker or Other Rep.

John Hancock Life Insurance Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application and information that you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by John Hancock Life Insurance Company. Your new policy provides thirty (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.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT, BROKER OR OTHER REPRESENTATIVE I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, 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 the material medical information 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's Signature

Signature of Agent, Broker or Other Rep.

Print Name of Agent, Broker or Other Rep.

Long-Term Care Insurance Personal Worksheet

John Hancock Life Insurance Company
Boston, MA 02117



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.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest 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: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The company has sold long-term care insurance since 1987 and has sold this policy since 2003. The company has never raised its rates for any long-term care policy we have sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium?

- 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 if the premiums will be more than 7% of your income.

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 2002 was \$57,000, but this figure varies across the country. In ten years, the national average annual cost would be about \$92,910 per year 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 one)

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

<input type="checkbox"/> The answers to the questions above describe my financial situation. or <input type="checkbox"/> I choose not to complete the financial information in this worksheet. (Check one)
<input type="checkbox"/> I acknowledge that the carrier and/or its agent (below) has 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. (This box must be checked).

Signed: _____
(Applicant) _____ Date __/__/__

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

Signed: _____
(Agent) _____ Date __/__/__

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.

Signed: _____
(Applicant) _____ Date __/__/__

A Company representative may contact you to verify your answers.

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.

Outline of Coverage

Long-Term Care Insurance Outline Of Coverage – Policy Series BSC-03 MD

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 may have 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.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This Outline of Coverage provides a very brief description of the important features of this Policy. You should compare this Outline of Coverage to outlines of coverage 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 have received services for which benefits are payable under the Nursing Home Benefit or the Assisted Living Facility Benefit. The waiver period will start the day after Your Elimination Period has been satisfied and will end on the date when benefits are no longer payable.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.** 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 within 30 days of the Policy receipt, 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:

Nursing Home Benefit Amount \$ _____

Home Health Care Benefit Amount \$ _____

Benefit Period/Policy Limit _____

Elimination Period _____ days

Benefit Increase Option Selected _____

Optional Benefits Selected: _____

(a) Subject to Policy requirements and limitations, this Policy provides coverage for actual charges up to the applicable Benefit Amount incurred by:

- a Nursing Home for room and board and care services;
- an Assisted Living Facility for room and board and care services;
- a Home Health Care Provider for the services of its personnel; and
- an Adult Day Care Center for attendance at the Center.

If You received services covered under the Nursing Home Benefit, Assisted Living Facility Benefit, and the Home Health Care Benefit on the same day, the only benefit payable for that day will be the greatest of: the Nursing Home Benefit, the Assisted Living Facility Benefit or the Home Health Care Benefit.

We will not pay for charges during the Elimination Period. 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.

(b) **Institutional Benefits:**

(1) **Nursing Home Benefit.** We will pay the Nursing Home Benefit Amount if You are confined in a Nursing Home and receiving Nursing Care (skilled or intermediate), Custodial Care, Hospice Care, or Respite Care. We will pay the actual charges incurred for confinement up to the Nursing Home Benefit Amount.

(2) **Nursing Home BedHold Benefit.** If You have been confined in a Nursing Home and need to go into the hospital temporarily, we will pay the Nursing Home to hold Your place until You return. We will pay this benefit, up to the Nursing Home Benefit Amount, for up to 21 days per calendar year due to hospital confinement.

(c) **Non-institutional Benefits:**

(1) **Home Health Care Benefit.** We will pay the Home Health Care Benefit Amount if You are receiving Home Health Care (including incidental homemaker services), Hospice Care or Respite Care in Your home, a rest home or in an Adult Day Care Center. We will pay the actual charges incurred for Home Health Care up to the Home Health Care Benefit Amount.

(2) **Assisted Living Facility Benefit.** We will pay the Assisted Living Facility Benefit Amount if You are confined in an Assisted Living Facility and receiving Custodial Care. We will pay the actual charges incurred for confinement in the Assisted Living Facility up to the Assisted Living Facility Benefit Amount. The Assisted Living Facility Benefit Amount is equal to 100% of the Nursing Home Benefit Amount.

(3) **Assisted Living Facility BedHold Benefit.** If You have been confined in an Assisted Living Facility and need to go into the hospital temporarily, we will pay the Assisted Living Facility to hold Your place until You return. We will pay this benefit, up to the Assisted Living Facility Benefit Amount, for up to 21 days per calendar year due to hospital confinement.

(d) **Eligibility for Payment of Benefits.** You are eligible for benefits under this Policy if:

- You need Substantial Assistance to perform at least two of the Activities of Daily Living; or
- You 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:

- satisfy Your Elimination Period;
- receive services while this Policy is in effect;
- must receive care or services that are consistent with Your care needs and are covered under this Policy, specified in a Plan of Care, and are in accordance with accepted medical and nursing standards of practice; and
- submit to Us 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 certification from a Licensed Health Care Practitioner that You meet the definition of a Chronically Ill Individual.

A “**Chronically Ill Individual**” means an individual who receives one of the following certifications:

- A Licensed Health Care Practitioner certifies 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.
- A Licensed Health Care Practitioner certifies that You require Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

This written 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 Spouse to access benefits under Your Policy if Your Spouse first exhausts the available benefits payable under his or her policy. You and Your Spouse 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 Spouse must also have added an identical SharedCare Benefit Rider to their policy naming You as Covered Person for that policy.
- **Shortened Benefit Period Nonforfeiture Benefit.** If Your Policy lapses because You have not paid the premium within the Grace Period, after being in force at least five (5) years, it will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This provides during the lifetime of the covered person for the same level of benefits available under the policy for that reduced benefit period which can be provided by the non forfeiture value if applied as a net single premium. In the event that You do not elect the Nonforfeiture Benefit, Your Policy will contain the Contingent Nonforfeiture Benefit provision.
- **Contingent Nonforfeiture Benefit.** The Contingent Nonforfeiture Benefit provides that in the event We increase rates by more than a specified amount shown in the Contingent Nonforfeiture provision, We will provide You with the opportunity to: pay the increased premium, decrease Your benefits to a level supported by Your current premium, or elect the Contingent Nonforfeiture Benefit. Under the Contingent Nonforfeiture Benefit, Your Policy will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This means that a reduced benefit will be payable instead of the full Policy Limit.

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.
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- 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 Home Health Care Agency 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 the District of Columbia except as described in the International Coverage section of this Policy.
- determined to be furnished as a result of a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

(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 not reimbursable by Medicare such as a Medicare deductible or coinsurance amounts).
- any state or federal workers' compensation, employer's liability or occupational disease law.

(c) **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 (unless provided under Hospice Care); transportation; items and services furnished at Your request for beautification, comfort, convenience or entertainment; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

(d) **Coordination with Other John Hancock Individual Long-Term Care Insurance Policies.**

We may reduce benefits payable under this Policy for Long-Term Care Services if We also pay benefits for such services under any other individual long-term care policy issued by Us. This includes policies providing Nursing Home, Assisted Living Facility and/or Home Health Care coverage whether payable on an expense reimbursement, indemnity or any other basis. Benefits will be reduced under this Policy, only when payment under this Policy and all other John Hancock individual long-term care policies combined would exceed the actual amount You incur for Long-Term Care Services. In no event will We pay under this Policy more than the difference between Your actual expenses and the amount payable by Your other policies with Us.

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, You should consider whether and how the benefits of this Policy may be adjusted. The benefit level(s) of this Policy will not increase over time, unless You have elected to purchase Inflation Coverage. You are guaranteed the option to buy Inflation Coverage. The Policy contains the option to purchase: Compound Inflation Coverage, Simple Inflation Coverage or a Guaranteed Purchase Option. These options are described at the end of this Outline of Coverage.

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 and optional benefits are found below.

Annual Premium

Base Policy with Compound Inflation	\$ _____
Base Policy with Simple Inflation	\$ _____
Base Policy with or without Guaranteed Purchase Option	\$ _____
• SharedCare	\$ _____
• Survivorship and Waiver Benefit	\$ _____
• Nonforfeiture	\$ _____
Total Annual Premium	\$ _____

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, .27 for quarterly and .09 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:

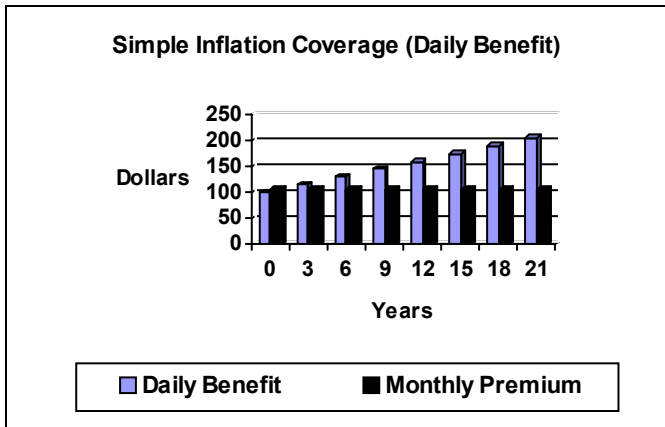
- You give Us proof of the Cognitive Impairment or Your inability to perform 2 of the Activities of Daily Living without Substantial Assistance; and
 - You pay all the unpaid overdue premiums.
- (c) This Policy includes an International Coverage Benefit. The International Coverage Benefit provides that 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. We will pay actual charges incurred for certain Long-Term Care Services up to the International Coverage Benefit Amount for a period of one-year. The International Coverage Benefit is equal to one-times the Nursing Home Benefit Amount.

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.

INFLATION PROTECTION AVAILABLE FOR YOUR LONG-TERM CARE INSURANCE POLICY

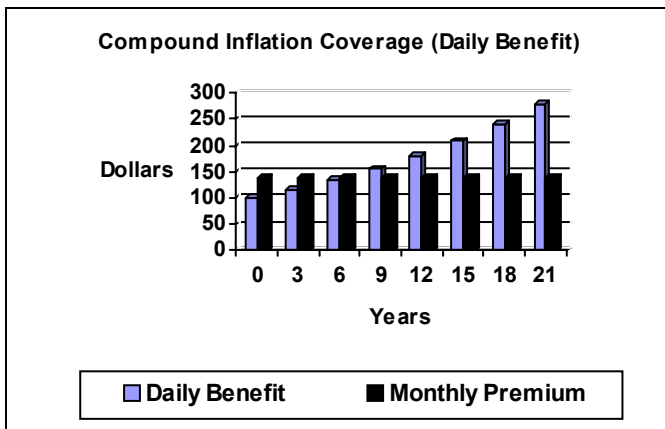
Simple Inflation Coverage. Your daily benefit(s) will increase by an amount equal to 5% of the daily Benefit Amount in effect when the Policy was issued. This annual increase is automatic and will occur on each Policy anniversary. The premium for Simple Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

The graph below shows the change in the daily Benefit Amount and the monthly premium under Simple Inflation Coverage. The graph illustrates a policy which has been issued to a person who is age 60 and has chosen a Nursing Home Benefit Amount of \$100 and a 4-year Benefit Period.



Compound Inflation Coverage. Your daily benefit(s) will increase by an amount equal to 5% of the daily Benefit Amount in effect during the prior Policy year. The annual increase is automatic and will occur on each Policy anniversary. The premium for Compound Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

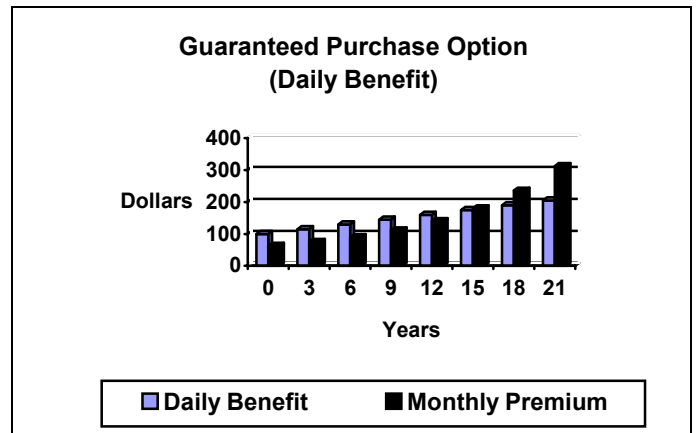
The graph below shows the change in the daily Benefit Amount and the monthly premium under Compound Inflation Coverage. The graph illustrates a policy, which has been issued to a person who is age 60, has chosen a Nursing Home Benefit Amount of \$100 and a 4-year Benefit Period.



Guaranteed Purchase Option. Every 3 years You will be provided with an opportunity to increase Your Benefit Amounts in an amount equal to 5, 10 or 15% of the original Benefit Amounts. The premium for any increase will be based on attained age. No additional underwriting will be required. You will be provided with the opportunity to increase Your Daily Benefit(s) as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the Option Dates). If You decline all or any portion of an increase when offered, such increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers every three years if You are otherwise eligible, unless You decline the offer two (2) times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. The premium for each increase will be based on Your age on the Option Date and the premium rates then in effect.

We will make You a one-time written offer on Your Policy anniversary which falls on or after Your 65th birthday to switch Your Guaranteed Purchase Option to 5% Compound Inflation Coverage. This offer will be available to You for a period of 60 days. Your new premium will be equal to the difference between the premium for 5% Compound Inflation Coverage and Your Guarantee Purchase Option coverage at your attained age for Your then current benefits. Your premium will not change, except as described in the Policy. If You elect to switch to 5% Compound Inflation Coverage, You will not receive any future Guaranteed Purchase Option offers.

The graph below shows the change in the daily Benefit Amount and the monthly premium if You elect all increases available to You. The graph illustrates a policy which has been issued to a person who is age 60 and has chosen a Nursing Home Benefit Amount of \$100 and a 4-year Benefit Period. Assume the person has elected a 15% increase on each Option Date. (Assume that the You did not elect the one-time offer to switch Your coverage to Compound Inflation Coverage.)



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.

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.

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.

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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

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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.

Long Term Care Insurance Potential Rate Increase Disclosure Form

John Hancock Life Insurance Company



1. Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is \$_____.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

The company will provide a description of when premium rate or rate schedule adjustments will be effective on the next billing date.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered “paid-up” with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your “paid-up” policy benefits are \$10,000 (provided you have a least \$10,000 of benefits remaining under your policy.)

**Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium	Issue Age	% Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		