

## Custom Care II Producer Application Instructions – New York

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

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

### CHECKLIST

✓	Form Name	Form #	Action
	Application Form	CC2APP05 NY	All answers to questions on the application form must be completed or checked off, both for affirmative and negative responses, including the rejection of inflation protection and nonforfeiture. Read all questions carefully. Under Part 2, certain benefit options cannot be selected in combination. Refer to page 2 of these instructions for details. The applicant must sign and date page 6. The producer must sign and date page 7. Backdating is not permitted.
	HIPAA Medical Authorization	LTCMED-03 NY	This form must be signed and dated by the applicant and submitted with the application in order for the underwriting process to begin. We ask that the date on this form match the date of the application form. We cannot accept an altered document.
	Advance Payment Receipt	LTCCR-03 NY	The amount of the advance payment is to be recorded and the applicant and producer must sign and date. We ask that the date on this form and check match the date of the application form. Submit one copy with the application. Leave one copy with the applicant.
	Replacement Form (if applicable)	15-LTC-03 NY	If replacing another long-term care insurance policy, use of this form is mandatory. The applicant and producer must sign. Submit one copy with the application. Provide one copy to the applicant.
	Certification of Domestic Partnership	LTC-DPC 9/03	Both partners must sign if seeking the Partner Discount. Submit with the application form.
	Suitability Personal Worksheet	LTC-PWK NY 5/05	Attempt to review your client's income and assets to determine if our minimum suitability standards are met. The 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	OCLTC-03 NY	Prior to presentation of an application form, provide a completed Outline to applicant. Sign and date any required sections.
	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.
	<b>Buyer's Guides</b>		
	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 applicants aged 65 and older, or Medicare eligible.

**RETURN A COPY OF THE PREMIUM ILLUSTRATION QUOTE WITH THE APPLICATION FORM**

## **INSTRUCTIONS**

1. Applications and all required forms must be received by John Hancock's home office within 30 days of the date the application was signed by your client. Incomplete applications and missing forms cause delays in the process and may be returned.
2. Use a black or blue ink pen. Draw a line through any errors made and have the applicant initial any corrections (**Do not use white-out**).
3. If the applicant has answered "yes" to any question in Part 4 (*Should You Proceed with this Application?*) 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" under Part 10 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. The Advance Payment Receipt must be completed.
7. If a payor other than the applicant intends to pay the premium by bank draft or credit card on behalf of the applicant, that individual must be provided with and complete form 7269R 3/01 (Automatic Deduction Plan) or form CCAUTH 10/04 (Credit Card Authorization).
8. Any applicable state-required forms are included in this application booklet (except for buyer's guides); please be sure you are using the correct state specific application booklet. Review all forms with the applicant.
9. Confirm that the application and all required forms have been signed where required and dated in all appropriate sections.

## **IMPORTANT NOTICE REGARDING BENEFIT COMBINATIONS**

Before completing **Part 2 (Choose Your Coverage)** of the application form, please notify your client about the following:

### **Inflation Options:**

A Guaranteed Purchase Option will automatically be included in the policy if the applicant does NOT elect: a Compound Inflation option; the 5% Simple Inflation option; the Survivorship Waiver option; and/or a Limited Payment option.

### **Optional Riders:**

SharedCare*	Not available with Lifetime Benefit Period, or Enhanced Return of Premium*.
Survivorship/Waiver	Not available with a Limited Payment Option.
Waiver of the Home Care Elimination Period*	Not available with the 180-day Elimination Period.
Additional Cash Benefit	Please see the Outline of Coverage for important Federal income tax information regarding this option.
Restoration of Benefits*	Not available with 2-year, 10* year or Lifetime* Benefit Period.
Enhanced Return of Premium Upon Death*	Not available with SharedCare*.

\* Not available to applicants aged 80-84

# Application for Individual Long-Term Care Insurance

## John Hancock Life Insurance Company



Note: Please initial any changes you make to this application. You may not make changes to dates or signatures.

### Part 1 – Please Tell Us About Yourself

1a. Name (First, M.I., Last): \_\_\_\_\_ 1b.  Male  Female

1c. Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

1d. SS#: \_\_\_\_\_ 1e. DOB (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ 1f. Birth Place (State, Country): \_\_\_\_\_

1g. Payor Name (if different from above): \_\_\_\_\_  
 Billing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

1h. Height: \_\_\_\_\_ 1i. Weight: \_\_\_\_\_

1j. Best time to call: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

### Part 2 – Choose Your Coverage

Asterisk (\*) items are not available for ages 80-84.

2a. Custom Care II Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)

Monthly Benefit Amount: \$ \_\_\_\_\_ \$3,100 - \$15,000 in \$100 increments (Metropolitan area)  
 \$2,170 - \$15,000 in \$100 increments (Non-Metropolitan area)  
 (Limit of \$7,500 for ages 80-84)

Daily Benefit Amount: \$ \_\_\_\_\_ \$100 - \$500 in \$10 increments (Metropolitan area)  
 \$70 - \$500 in \$10 increments (Non-Metropolitan area)  
 (Limit of \$250 for ages 80-84)

2b. Benefit Periods (Years):  2  3  4\*  5\*  6\*  10\*  Lifetime\*  
*(The Benefit Period is used to determine the Policy Limit shown on the Policy Schedule.)*

2c. Elimination Period (Dates of Service):  30\*  60\*  90  180

2d. Inflation Protection Options:

None

5% Simple Inflation

5% Compound Inflation *(Benefit Amounts and Policy Limit increase at 5% compounded annually.)*

5%/3% Compound Inflation *(Benefit Amounts increase at 5% compounded annually, while Policy Limit increases at 3% compounded annually. Therefore, your benefits may last for a shorter period of time than the Benefit Period you elected.)*

2e. Rejection of Inflation Protection: *(Please read. You must check the box below if you do not select Compound or Simple Inflation.)*

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 the Compound and Simple Inflation options and I reject inflation protection.

2f. Optional Benefits:

Partner Benefits

SharedCare\* *(Spouse/Partner Name)* \_\_\_\_\_

Survivorship/Waiver

Additional Home Care Options

Waiver of the Home Care Elimination Period\*

Additional Cash Benefit

Additional Benefit Protection Options

Restoration of Benefits\*

Enhanced Return of Premium Upon Death\* *(Complete question 3a if you elected this benefit.)*

Nonforfeiture

2g. Rejection of Nonforfeiture: *(You must check the box below if you have not elected Nonforfeiture.)*

I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.

## Part 3 – Discounts & Other Needed Information

### Beneficiary Designation

- 3a. If you are age 64 or younger or elected the optional Enhanced Return of Premium Upon Death, you must elect a beneficiary. If you leave this question blank, we will designate your estate as your beneficiary. You may change your beneficiary at any time by notifying us in writing. (Name & Address): \_\_\_\_\_

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

### Marital/Partner Discount

- 3b. Are you married? .....  Yes  No
- 3c. If you are not married, are you in a committed relationship with a Partner with whom you have been living together for at least the past 3 years? .....  Yes  No
- 3d. Is your Spouse or Partner also applying for this insurance or does he/she currently have an existing John Hancock individual long-term care insurance policy?  
If YES, provide info below. ....  Yes  No  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Policy # (if available): \_\_\_\_\_  
You and your Partner must both complete the New York Domestic Partner Declaration form or an alternative affidavit appropriate to the jurisdiction where your partnership was established.

### Marketing Group Discount

- 3e. Do you belong to a marketing group? .....  Yes  No  
If YES, Marketing Group #: \_\_\_\_\_ and Marketing Group Name: \_\_\_\_\_  
(Please also provide proof of employment/membership with marketing group.)

## Part 4 – Should You Proceed with this Application?

Please check YES or NO beside each question.

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

### PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

If you answered YES to any of the questions in Part 4, we suggest that you do not submit an application. If you answered NO to every question, please continue.

## Part 5 – Medical History & Lifestyle

5a. Have you consulted with your primary care physician within the past 18 months?  Yes  No

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Please check YES or NO beside each question.

5b. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?  Yes  No

5c. To the best of your knowledge and belief, within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?

- |   |                          |     |                          |    |
|---|--------------------------|-----|--------------------------|----|
| 1. <b>Circulatory Disorders:</b> 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"/> | Yes | <input type="checkbox"/> | No |
| 2. <b>Endocrine and Pituitary Disorders:</b> Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. <b>Cancers:</b> Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas.....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. <b>Genitourinary Disorders:</b> Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. <b>Gastrointestinal Disorders:</b> Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders, Cirrhosis.....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. <b>Neurological Disorders:</b> Cerebral Atrophy, Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. <b>Blood Disorders:</b> Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. <b>Musculoskeletal Disorders:</b> Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Polymyalgia Rheumatica, Osteopenia, Paralysis, Crest.....                                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. <b>Respiratory Disorders:</b> Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease.....   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. <b>Eye &amp; Ear Disorders:</b> Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 11. <b>Substance Abuse:</b> Alcoholism, Drug dependency, Illicit drug use.....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

5d. Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?  Yes  No

5e. Within the last 5 years has any surgery or test(s) been recommended that have not been performed?  Yes  No

5f. Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated?  Yes  No

If YES, list medical reason: \_\_\_\_\_

5g. Are you receiving any disability benefits?  Yes  No

If YES, list medical reason: \_\_\_\_\_ Disability % \_\_\_\_\_

**PLEASE NOTE: 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. The nurse will simply ask you questions to help us underwrite your application.**

5h. **MEDICAL HISTORY DETAILS – If you answered YES to any of questions 5c through 5g, provide full detail here.**

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

## Part 5 - Continued

5i. **MEDICATIONS** – List all prescription medications taken at any time over the past 12 months.

Medication	Dosage	Frequency	Reason Prescribed	Physician Name

**LIFESTYLE** – Please complete the following questions if you are age 64 or younger.

- 5j. Are you currently employed? If so, what is your occupation: \_\_\_\_\_  Yes  No
- 5k. In the past 10 years, have you done or do you intend to do any of the following activities: Skin/scuba diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? If "Yes" frequency: \_\_\_\_\_  Yes  No
- 5l. In the past 10 years, have you been convicted of two or more felony motor vehicle moving violations or had a driving license suspended or revoked? If "Yes", license number and state: \_\_\_\_\_  Yes  No

## Part 6 – Insurance History

Please check YES or NO beside each numbered question or statement.

- 6a. Are you covered by Medicaid? .....  Yes  No
- 6b. Have you had another long-term care, nursing home and home care, nursing home only, home health care insurance policy or certificate in force during the last 12 months? If YES, please provide details below.....  Yes  No
- 6c. Do you have another long-term care, nursing home and home care, nursing home only, home health care, accident & health insurance policy or certificate in force (including a health care service, Health maintenance organization or Medicare Supplement contract)? If YES, please provide details below. ....  Yes  No
- 6d. Do you intend to replace any of your long-term care, nursing home and home care, nursing home only, home health care, medical or health insurance coverage with the policy for which you are applying? If YES, please provide details below.....  Yes  No

Company	Policy/Cert#	Annual Premium	Benefit Type & Amounts	Currently In Force?	If Lapsed, Date of Lapse	Is it being replaced?

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

## Part 7 – Payment & Administration

7a. **Payment Type:** You must choose **one** of the following options:

1.  **Direct Bill**      Select a payment frequency:    Annually    Semi-Annually    Quarterly

**Direct Bill Advance Payment:**

- I have enclosed my advance payment in the amount of \$ \_\_\_\_\_ (minimum of one month's premium)

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

2.  **Bank Draft:**

Insured's Name: \_\_\_\_\_ Bank Account #: \_\_\_\_\_

Account Type:    Checking    Savings      Bank Name: \_\_\_\_\_

Bank Routing Number: \_\_\_\_\_ Select Draft Day(1<sup>st</sup>-28<sup>th</sup>): \_\_\_\_\_

Name(s) of Depositor(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.  **Credit/Debit Card:**

Payment Frequency:    Quarterly    Monthly

Card Type:    Mastercard    Visa

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

4.  **List Bill**      List Bill Group #: \_\_\_\_\_      List Bill Group Name: \_\_\_\_\_

7b. **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.*

7c. **Special Requests:**

\_\_\_\_\_

## 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 NOT to designate any person to receive such notice.

*OR*

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

Name (First, M.I., Last): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## Part 9 – Agreement & Acknowledgment

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

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

For the purpose of underwriting my application, by making an advance payment with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. And, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen. I understand that completing this application or making an advance payment does not guarantee that my application will be approved. If my application is approved, the effective date of my policy will be stated in the policy issued to me. I understand that in order to keep my policy in force, I must pay all the required premiums when due. I understand that if my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.

**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".

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

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I authorize John Hancock to deduct from my bank or charge my credit/debit card the advance payment and all recurring required premiums, based upon my selected method of payment as shown in Part 7. I understand that the premiums deducted or charged will be as shown on the policy or the most recent premium change notice issued to the policyholder by John Hancock. This authorization is valid indefinitely until such time as I provide written notice of cancellation to John Hancock at the servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

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.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

Signed at:

\_\_\_\_\_  
City

\_\_\_\_\_  
State

## Part 10 – Producer/Agent's Statement

### Replacement:

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

To the best of my knowledge, replacement of other insurance  is/  is not involved in this transaction. Listed below are all other health insurance policies I have (i) sold to the Applicant which are still in force; and (ii) sold to the Applicant in the last five years which are no longer in force.

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:** Risk classification quoted:  Preferred  Select  Class I (25%)  Class II (50%)

**Note:** Underwriting will determine the best risk class, regardless of class quoted to the applicant. We will communicate any change to you.

Signature of Licensed Agent: \_\_\_\_\_

Agent Name (Please print): \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please attach the illustration presented to the Applicant.**

## Credit for Application

Producer/Agent Name (Please print): \_\_\_\_\_

Agency/Bank/Firm Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Tel. #: \_\_\_\_\_

Annual Premium: \$ \_\_\_\_\_

Fax#: \_\_\_\_\_

JH Agency Code (if known): \_\_\_\_\_

Email: \_\_\_\_\_

JHFN Career Only:

Payroll Number: \_\_\_\_\_

Contract Code: \_\_\_\_\_

**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#: \_\_\_\_\_

Agency/Firm: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Percentage:

Agent SS#: \_\_\_\_\_

Agency/Firm: \_\_\_\_\_

**Attach producer/agent's  
business card here**

Home Office Only:

# HIPAA Medical Authorization

John Hancock Life Insurance Company



**This is a HIPAA compliant authorization.** "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.
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 applicable law. My health information may be re-disclosed and no longer protected HIPAA. This is because 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

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. Adverse changes in the company's underwriting rules after the Receipt Date will not affect insurability.

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

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

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

On behalf of John Hancock Life Insurance Company:

Agent Signature: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Advanced Payment Program

John Hancock Life Insurance Company

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:

- iii. the date of this Receipt, or
- iv. the date you complete any physical exams or tests required by us,

will not affect the underwriting of your application.

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

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

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

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

On behalf of John Hancock Life Insurance Company:

Agent Signature: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

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

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_

Applicant's Signature

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

\_\_\_\_\_  
Signature of Agent, Broker or Other Rep.

\_\_\_\_\_  
Print Name of Agent, Broker or Other Rep.

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

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

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

The above "Notice to Applicant" was delivered to me on:

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Applicant's Signature

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

\_\_\_\_\_  
Signature of Agent, Broker or Other Rep.

\_\_\_\_\_  
Print Name of Agent, Broker or Other Rep.

## New York Domestic Partner Declaration

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

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

# Long-Term Care Insurance Personal Worksheet



JOHN HANCOCK LIFE INSURANCE COMPANY

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

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

## Premium Information

Policy Form Number: \_\_\_\_\_

The premium for the coverage you are considering will be \$\_\_\_\_\_ per \_\_\_\_\_.

Type of Policy: Guaranteed Renewable

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

## Rate Increase History

John Hancock has sold individual long-term care insurance since 1987 and has sold this John Hancock policy since 2003. In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company block of individual long-term care insurance. John Hancock raised the premiums rates on the Fortis policy series listed below:

States	Fortis Policy Series	Years Fortis Policy Series was Available for Purchase	Fortis Policy Series Rate History
CA, FL, IL, IA, KS, KY, MO, NE, ND, OH, SD and TX.	Policy series 4040, 4042 & 4043; With associated riders 2020, 2021, 2022 & 2023 (where applicable)	1993 - 1997	30% increase in 2003
All states and DC.	Policy series 4000, 4002, 4006, 4008, 4040, 4042 & 4043	1993 - 1997	In 2005: <ul style="list-style-type: none"> <li>• 8% - 40% increase for series 4040, 4000 and 4006</li> <li>• 12% - 56% increase for series 4042, 4002 and 4008</li> <li>• 25% increase on series 4043 in OR, RI &amp; VT</li> </ul>

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

## Questions Related to Your Income

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

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

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

What is your annual income? (check one)

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

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

- No change       Increase       Decrease

*If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy 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 2004 was \$70,080, but this figure varies across the country. In ten years, the national average annual cost would be about \$114,152 if costs increase 5% annually.*

What elimination period are you considering? Number of days: \_\_\_\_\_

Approximate cost: \$\_\_\_\_\_ for that period of care

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

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

### Questions Related to Your Savings and Investments

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

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

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

- Stay about the same       Increase       Decrease

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

### Disclosure Statement

**(Check one)**

- The information provided in this worksheet accurately describes my financial situation.  
or  
 I choose not to complete the financial information in this worksheet.

---

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

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

Applicant's Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_

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

Agent's Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_

Agent's Printed Name \_\_\_\_\_

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

Applicant's Signature \_\_\_\_\_ Date \_\_/\_\_/\_\_

*A Company representative may contact you to verify your answers.*



LONG TERM CARE INSURANCE

Control No. (if known): \_\_\_\_\_

JOHN HANCOCK LONG TERM CARE INSURANCE SITUS VERIFICATION FORM

INSTRUCTIONS

Use this form in conjunction with a John Hancock LTCI policy when the applicant is signing the application outside his/her resident state. Please be sure to check off the appropriate box(es) in section 2 to indicate why the contract is not being signed in the state where the applicant resides. Only the agent/broker is required to sign this form.

Please indicate the state in which the application is signed: \_\_\_\_\_

Section 1

Applicant name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Resident/domicile address of applicant: \_\_\_\_\_

\_\_\_\_\_ ( ) \_\_\_\_\_  
City State Zip Telephone

Section 2

Secondary residence. \_\_\_\_\_  
Address

\_\_\_\_\_ Address

\_\_\_\_\_ ( ) \_\_\_\_\_  
City State Zip Telephone

Employment: \_\_\_\_\_  
Employer/business name

\_\_\_\_\_ Address

\_\_\_\_\_ Address

\_\_\_\_\_ ( ) \_\_\_\_\_  
City State Zip Telephone

Prior business relationship involving financial service products: From: \_\_\_\_\_ To: \_\_\_\_\_  
Approximate dates of relationship

Nature of relationship: \_\_\_\_\_

Section 3

\_\_\_\_\_ ( ) \_\_\_\_\_  
Agent/Broker Name Telephone

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Agent/Broker Signature Date

Please submit this form with your LTCI Application

## 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.

# Disclosure Statement

## Long-Term Care Insurance Disclosure Statement Custom Care II - Policy Series LTC-03 NY & SG-03 NY

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



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

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

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

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

4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**
  - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
  - (b) **WAIVER OF PREMIUM.** We will waive the payment of premiums under this Policy if You have received services for which benefits are payable under the Long-Term Care 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. The premium will not be waived, however, if benefits are only being received under the Stay at Home Benefit or Care Advisory Services Benefit.
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, 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:**

Long-Term Care Benefit Amount            \$ \_\_\_\_\_  
*(You may elect a monthly or daily option.)*

Benefit Period/Policy Limit                \_\_\_\_\_

Elimination Period                            \_\_\_\_\_ days

Benefit Increase Option Selected        \_\_\_\_\_

Optional Benefits Selected:

\_\_\_\_\_

\_\_\_\_\_

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

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

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

In addition, if Your stay in a Nursing Home or Assisted Living Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence. Any unused portion of Your Long-Term Care Benefit Amount will remain in the Policy Limit. Any benefit paid under this provision will reduce Your Policy Limit.

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

If You receive Home Health Care for one or more days in a Calendar Week, We will apply seven days toward the satisfaction of Your Elimination Period, except if Respite Care is being received during the Calendar Week. If Respite Care is received during a Calendar Week, only the actual Dates of Service other than Respite Care will be applied toward satisfaction of Your Elimination Period. Please note that there will be no credit for days that occur before Your first Date of Service.

**(b) Additional Benefits.**

- **Respite Care Benefit.** During Your Elimination Period, We will pay the actual charges incurred for Respite Care up to the Respite Care Benefit Amount per day for up to 21-days in any calendar year. This means You do not need to satisfy Your Elimination Period before receiving benefits for Respite Care. Days that You receive Respite Care will not count toward the satisfaction of Your Elimination Period. The Respite Care Benefit Amount is equal to 1/30<sup>th</sup> of the Long-Term Care Benefit Amount if the monthly option is chosen, or the Long Term Care Benefit Amount if the daily option is chosen. After Your Elimination Period has been satisfied, We will

pay the actual charges incurred for Respite Care up to the Long-Term Care Benefit Amount as shown in the Policy Schedule.

- **Care Advisory Services Benefit.** We will pay the Care Advisory Services Benefit up to the Care Advisory Services Benefit. This benefit is equal to 1/3 of the Long-Term Care Benefit Amount if the monthly option is chosen or 10-times the Long-Term Care Benefit Amount if the daily option is chosen. Care Advisory Services include: an assessment of the need for long-term care services; the development of a plan of care that is consistent with the assessment; coordination of the delivery of care and services; and monitoring the care and services delivered. You must meet the eligibility requirements in the Policy. You do not have to satisfy the Elimination Period to receive this benefit. Benefits paid under the Care Advisory Services Benefit do not reduce the Policy Limit.
- **Stay at Home Benefit.** The Stay at Home Benefit can be used to pay for a variety of Your long-term care expenses while You are living in Your Home that are not otherwise covered under the Policy. Stay at Home Services include:
  1. Home Modifications;
  2. Emergency Medical Response Systems;
  3. Durable Medical Equipment;
  4. Caregiver Training;
  5. Home Safety Check; and
  6. Provider Care Check.

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

- **Return of Premium upon Death Benefit.** *Important Notice - The Return of Premium Benefit is not applicable to You if You are age 65 or older.*

If You die before Your 65th birthday, We will pay to Your beneficiary a Return of Premium upon Death Benefit if Your Policy is in force on the date of Your death. The Return of Premium upon Death Benefit will be calculated by subtracting the sum of all benefits paid under Your Policy for charges incurred prior to the date of Your death from the sum of all premiums paid for Your Policy (accumulated without interest).

*Important Notice Regarding Federal Income Tax Law – Please note that the payment of the Return of Premium Benefit may have Federal Income Tax implications for Your estate or beneficiary. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.*

- **Double Coverage for Accident Benefit.** *(This benefit will only be included in the Policy if You are under age 65 and have met Our underwriting guidelines for this benefit.)*

If You become eligible for benefits under this Policy due to an Accidental Injury prior to Your 65<sup>th</sup> birthday, We will pay the actual charges incurred by You for Long-Term Care Services up to the Double Coverage for Accident Benefit Amount. The Double Coverage for Accident Benefit Amount is equal to 2-times the Long-Term Care Benefit Amount. Benefits paid in excess of the Long-Term Care Benefit Amount will **not** be deducted from the Policy Limit. We will never pay more than the actual charges You incur for care and services covered by this Policy. Payment of the Double Coverage for Accident Benefit will begin only after You have satisfied Your Elimination Period.

- (c) **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.

(d) **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 one of the following written certifications:

- A Licensed Health Care Practitioner must certify 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 must certify 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.

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

- **SharedCare.** The SharedCare Rider allows Your Partner to access benefits under Your Policy if Your Partner first exhausts the available benefits payable under his or her policy. You and Your Partner may both receive benefits under Your Policy at the same time. In no event will We pay benefits that exceed the maximum Policy Limits of both policies combined. Your Partner must also have added an identical SharedCare Benefit Rider to his/her policy naming You as Covered Person for that policy.
- **Survivorship and Waiver Benefit.** The Survivorship and Waiver of Premium Benefit rider provides that Your premiums will be waived in the event Your Partner dies or goes on claim after both policies have been in force for at least 10 years and no claims were payable in the first 10 years. Payments will

resume if Your Partner's premiums are no longer waived or Your Partner's policy terminates.

- **Waiver of the Elimination Period for Home Care.** We will waive the requirement that you satisfy the Elimination Period if You are receiving Home Health Care, Hospice Care, or Adult Day Care. The Elimination Period must still be satisfied before benefits are payable under Long-Term Care Benefit for confinement in a Nursing Home or an Assisted Living Facility. However, days which the Home Health Care Elimination Period is waived will count toward meeting the facility Elimination Period.
- **Restoration of Benefits.** We will restore the Policy Limit on a one-time basis if You are not eligible for the payment of benefits for a continuous period of 180 days.
- **Additional Cash Benefit.** In addition to the monthly or daily benefits, this rider will provide a cash indemnity in order to help You stay at home. No benefit is payable in any month if You are confined in a Nursing Home or Assisted Living Facility for any part of that month. The Additional Cash Benefit Amount is equal to 15% of the Long Term Care Benefit Amount (if You elect the monthly option) or 4.5 times the Long-Term Care Benefit Amount (if You elect the daily option).

*Important Notice Regarding Federal Income Tax Law in the Event You Elected a Long-Term Care Benefit Amount in Excess of \$150 per Day or \$4,500 per Month --* In the event You elected a Long-Term Care Benefit Amount in excess of \$150 per day or \$4,500 per month, as the case may be, benefits paid under the Additional Cash Benefit are subject to certain aggregation rules under the Internal Revenue Code for purposes of Federal Income Tax calculation. This means that Additional Cash Benefits will be aggregated with other benefits paid under the Policy. In the event that total payments exceed the "Per Diem Limitation" for that period, any benefits paid in excess of such limitation are includable in gross income. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.

- **Enhanced Return of Premium upon Death Benefit.** We will pay to Your beneficiary the Enhanced Return of Premium upon Death Benefit if Your Policy is in force on the date of Your death regardless of Your age at the time

of Your death. The Enhanced Return of Premium upon Death Benefit will be calculated by subtracting the sum of all benefits paid under Your Policy for charges incurred prior to the date of Your death from the sum of all premiums paid for Your Policy (accumulated without interest).

*Important Notice Regarding Federal Income Tax Law – Please note that the payment of the Return of Premium Benefit may have Federal Income Tax implications for Your estate or beneficiary. You are advised to review this benefit with a qualified tax professional or attorney to determine any such tax impact.*

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

## 10. LIMITATIONS AND EXCLUSIONS

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

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

- for intentionally self-inflicted injury.
- required as a result of alcoholism or drug addiction (unless drug addiction was a result of the administration of drugs as part of treatment by a Physician).
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- due to participation in a felony, riot or insurrection.
- normally not made in the absence of insurance.
- provided by a member of Your Immediate Family, unless:
  - the family member is one of the following professionals -- a duly licensed registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed social worker, or registered dietitian; and

- the family member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Center or 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.

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

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

(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; 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.

**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 Disclosure Statement.

**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 (includes inflation, if any)	\$ _____
• SharedCare	\$ _____
• Survivorship-Waiver Benefit	\$ _____
• Waiver of the Elimination Period For Home Care	\$ _____
• Restoration of Benefits	\$ _____
• Additional Cash Benefit	\$ _____
• Enhanced Return of Premium 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. The International Coverage Benefit will not be paid in excess of an amount equal to: 365-times the Long-Term Care Benefit Amount if You elected the daily Benefit Amount option; or 12-times the Long-Term Care Benefit if You elected the monthly Benefit Amount option.

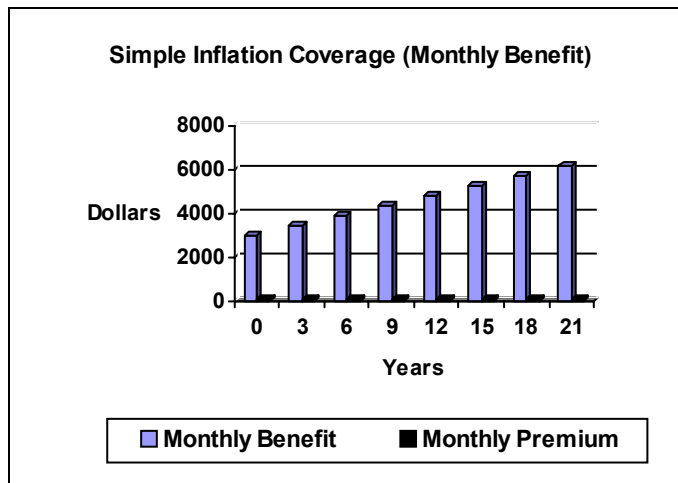
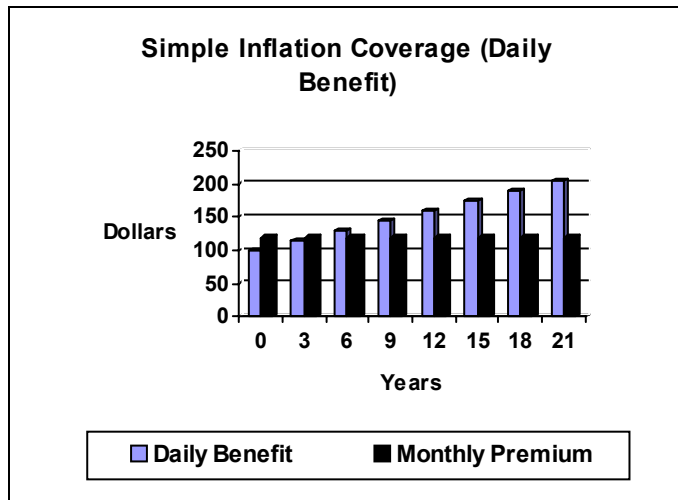
(d) The expected benefit ratio for this policy is 60% for issue ages up to 65 and 65% for issue age 65 and older. This ratio is the portion of future premiums, which we expect to return as benefits, when average over all people with this policy.

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

## INFLATION PROTECTION AVAILABLE FOR YOUR LONG-TERM CARE INSURANCE POLICY

**Simple Inflation Coverage.** Your Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care 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.

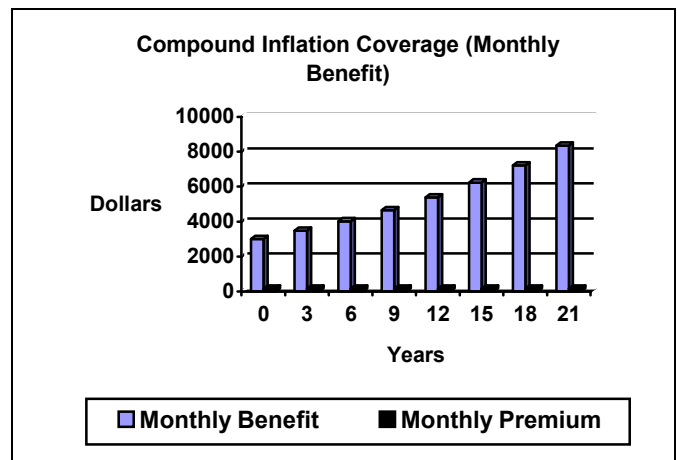
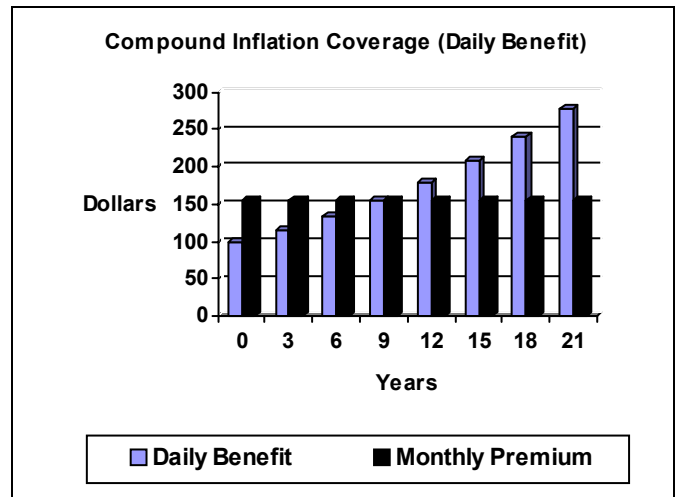
The graphs below show the change in the daily and monthly Benefit Amount and the monthly premium under Simple Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a monthly Long-Term Care Benefit Amount of \$3,000 or daily Long-Term Care Benefit Amount of \$100, and a 4-year Benefit Period.



**Compound Inflation Coverage.** Your Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care 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.

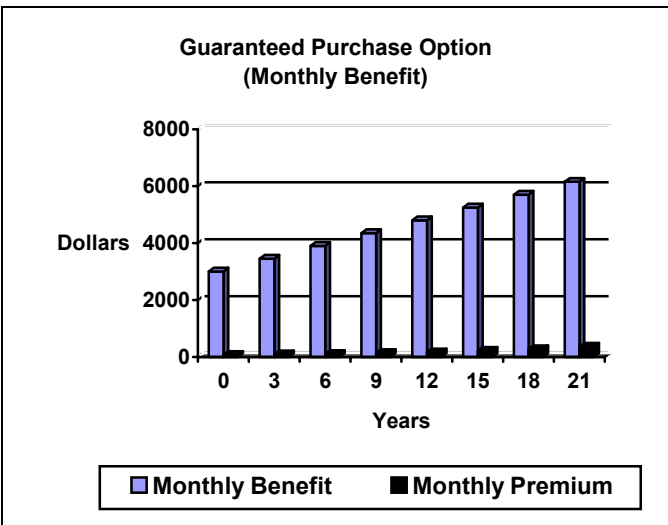
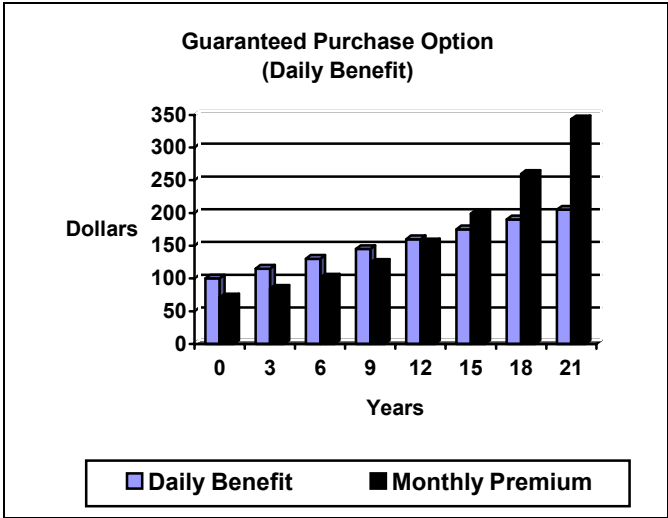
The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under Compound Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a monthly Long-Term Care Benefit Amount of \$3,000 or daily Long-Term Care Benefit 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 Long-Term Care Benefit Amount in an amount equal to 5, 10 or 15% of the original Long-Term Care Benefit Amount. 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 Long-Term Care Benefit Amount as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the Option Dates). No offers will be made if any benefits have been paid within the past 2 years or You are older than 91. If You decline all or any portion of an increase when offered, such increase will not be available on any future Option Date. 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 65<sup>th</sup> 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 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. If You elect to switch to 5% Compound Inflation Coverage, You will not receive any future Guaranteed Purchase Option offers.

The graphs to the side show the change in the daily or monthly Benefit Amount and the monthly premium if You elect all increases available to You. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a monthly Long-Term Care Benefit Amount of \$3,000 or daily Long-Term Care Benefit Amount of \$100, and a 4-year Benefit Period. Assume the person has elected a 15% increase on each Option Date. (Assume that 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

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**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.**

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#### **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.

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#### **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.

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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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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 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.

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### **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.

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### **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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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.

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.

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## 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.