

SERFF Tracking Number: MANU-125742058 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 40055
Company Tracking Number: CP4000/01/02/03/04/05/06 (09/2008)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: CP4000/01/02/03/04/05/06 (09/2008)
Project Name/Number: CP4000/01/02/03/04/05/06 (09/2008)/CP4000/01/02/03/04/05/06 (09/2008)

Filing at a Glance

Company: John Hancock Life Insurance Company (U.S.A.)

Product Name: CP4000/01/02/03/04/05/06 (09/2008) SERFF Tr Num: MANU-125742058 State: ArkansasLH

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40055

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Approved-Closed

CP4000/01/02/03/04/05/06 (09/2008)

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Authors: Helene Landow, Karren

Disposition Date: 08/27/2008

Phair, Debbie Tom, Jacqueline Lau,
Jacqueline Back

Date Submitted: 08/25/2008

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: CP4000/01/02/03/04/05/06 (09/2008)

Status of Filing in Domicile: Authorized

Project Number: CP4000/01/02/03/04/05/06 (09/2008)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Exempt in
Michigan

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/27/2008

State Status Changed: 08/27/2008

Deemer Date:

Corresponding Filing Tracking Number: CP4000/01/02/03/04/05/06 (09/2008)

Filing Description:

We are submitting the above new application forms for your approval. These forms will be used with state approved Universal Life and Variable Life policies in the corporate-owned and bank-owned individual life insurance markets.

SERFF Tracking Number: MANU-125742058 *State:* Arkansas
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TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: CP4000/01/02/03/04/05/06 (09/2008)
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These new forms do not replace any currently approved forms and will be available electronically to print locally without any change in the pre-formatted content.

No part of this filing contains any unusual or controversial items that deviate from normal company or industry standards.

CP4000US (09/2008), Master COLI Application for Life Insurance, will be used on multi-life cases where the underwriting criteria for the insured is based primarily on actively at work and smoking status. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4001US (09/2008), Simplified Application for Life Insurance, will be used with cases of 5 to 150 participants and when limited evidence of insurability is required. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4002US (09/2008), GI Application for Life Insurance, will be used with cases of 10 or more participants and when the selection criteria is based on actively at work on a full-time basis and smoking status. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4003US (09/2008), Simplified Consent to Life Insurance, will be used to obtain consent to be insured and to ask simplified health questions for each individual. This form will be used in conjunction with the Master COLI application and insurance schedule.

CP4004US (09/2008), GI Consent to Life Insurance, will be used to obtain consent to be insured and ask about activity at work and smoking status for each Proposed Life Insured. This form will be used in conjunction with the Master COLI application and insurance schedule.

CP4005US (09/2008), Insurance Schedule, will be used with the Master COLI application to list the data for coverage of individuals to be insured.

CP4006US (09/2008), Application Supplement – Customized Schedule, if applicable, will be used with the Master COLI Application, Simplified Application and GI Application for Life Insurance forms, to list data for scheduled custom or increasing Supplemental Face Amounts.

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The Service Office Address wherever shown on the submitted form is being filed as variable information [shown in brackets] in case of future change.

Company and Contact

Filing Contact Information

Jacqueline Lau, Contract Analyst Jacqueline_Lau@jhancock.com
 200 Bloor St E (416) 852-7906 [Phone]
 Toronto, ON M4W 1E5 (416) 926-3121[FAX]

Filing Company Information

John Hancock Life Insurance Company CoCode: 65838 State of Domicile: Michigan
 (U.S.A.)
 P. O. Box 600 Group Code: 904 Company Type: insurance/financial
 Contracts and Compliance
 Buffalo, NY 14201-0600 Group Name: State ID Number:
 (416) 926-3000 ext. [Phone] FEIN Number: 01-0233346

Filing Fees

Fee Required? Yes
 Fee Amount: \$140.00
 Retaliatory? No
 Fee Explanation: \$20.00 per form and there are 7 forms.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company (U.S.A.)	\$140.00	08/25/2008	22107731

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	08/27/2008	08/27/2008

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Disposition

Disposition Date: 08/27/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Statement of Variability		Yes
Form	Master COLI Application for Life Insurance		Yes
Form	Simplified Application for Life Insurance		Yes
Form	GI Application for Life Insurance		Yes
Form	Simplified Consent to Life Insurance		Yes
Form	GI Consent to Life Insurance		Yes
Form	Insurance Schedule		Yes
Form	Application Supplement – Customized Schedule		Yes

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Form Schedule

Lead Form Number: CP4000/01/02/03/04/05/06 (09/2008)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	CP4000US (09/2008)	Application/ Enrollment Form	Master COLI Application for Life Insurance	Initial		40	CP4000US.pdf
	CP4001US (09/2008)	Application/ Enrollment Form	Simplified Application for Life Insurance	Initial		41	CP4001US.pdf
	CP4002US (09/2008)	Application/ Enrollment Form	GI Application for Life Insurance	Initial		40	CP4002US.pdf
	CP4003US (09/2008)	Application/ Enrollment Form	Simplified Consent to Life Insurance	Initial		47	CP4003US.pdf
	CP4004US (09/2008)	Application/ Enrollment Form	GI Consent to Life Insurance	Initial		70	CP4004US.pdf
	CP4005US (09/2008)	Application/ Enrollment Form	Insurance Schedule	Initial		50	CP4005US.pdf
	CP4006US (09/2008)	Application/ Enrollment Form	Application Supplement – Customized Schedule	Initial		59	CP4006US.pdf



Master COLI Application for Life Insurance

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as The Company)

Service Office:

COLI Unit
197 Clarendon Street
Boston MA 02116-5010

• Print and use black ink. Any changes must be initialed by the Owner's Authorized Officer.

Owner

1. a) Name(s) of Owner(s)

b) Address Street No. & Name, City, State, Zip code

c) Tax ID Number

Beneficiary Information

2. Owner Other

Policy Details - For Variable Insurance Policies, complete required Application Supplement for Investment Allocation and Investor Suitability form.

3. Plan Name Corporate VUL Other

4. Supplementary Benefits

Overloan Protection Rider

Return of Premium Death Benefit (with DB Option 1 only)

Increase Rate Yes _____ % No

Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %

Supplemental Face Amount (SFA) (Check only one option below.)

Level Supplemental Face Amount (SFA)

Custom or increasing SFA schedule. Please complete Application Supplement - Customized Schedule form.

Other

5. Insurance amounts to be applied for in accordance with Insurance Schedule or Census and Consent to Life Insurance forms.

6. Death Benefit Option Option 1 (Face Amount) Option 2 (Face Amount plus Policy Value)

7. Loan Interest Rate Fixed Other %

8. Life Insurance Qualification Test Guideline Premium (GPT) Cash Value Accumulation (CVAT)

Note: Elected test cannot be changed after the policy is issued. You may request an Illustration on both tests before making your election.

Premiums

9. Amount \$ Frequency Annual Other

Premium Notices and Correspondence

10. a) Send Premium Notices to: (Select one)

Owner Proposed Life Insured

Other: Name Street No. & Name, Apt No., City, State, Zip code

b) Send Policy Correspondence to: (Select one)

Owner Proposed Life Insured Same as 10. a) above

Other: Name Street No. & Name, Apt No., City, State, Zip code

Existing Insurance - Owner Replacements

11. Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums due on the new policy or contract?

Yes No If Yes, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities.

Special Requests

12. a) Special Policy Date b) Other

Telephone and/or Internet Transfer/Allocation Change Authorization

13. I understand and agree that:

- a) By checking one of the boxes below, I am authorizing The Company to accept telephone and Internet transfers and allocation changes. Telephone and Internet transfers and allocation changes will also be subject to the terms and conditions of the policy, and the administrative requirements of The Company.
- b) **The Company will honor telephone and Internet instructions from anyone who provides correct identifying information.** The Company, its agents or representatives of employees who act on its behalf will not be subject to any claim, liability, loss, expense or cost if acted on in good faith upon telephone or Internet instructions it reasonably believes to be genuine in reliance on this signed authorization.
- c) The Company, at its option alone and without prior or subsequent notice to the Owner(s), or any other person or representative of the Owner(s), may record all or part of any telephone conversation containing telephone transfer and/or allocation change instructions.

- d) All terms of the Authorization are binding upon the agents, heir and assignees of the Owner(s).
- e) This Telephone and Internet Transfer/Allocation Change Authorization will be effective until such time as (a) written revocation is received by The Company's Service Office, or (b) The Company discontinues this privilege, whichever occurs first.

Please check (✓) ONLY one box:

- I authorize The Company to accept telephone and Internet instructions from me or any co-owner.
- I authorize The Company to accept telephone and Internet instructions from me, any co-owner or our Registered Representative.

Declarations and Owner/Taxpayer Certification

DECLARATIONS

I declare that the statements and answers in this application, and any form that is made part of this application, are complete and true to the best of my knowledge. I believe they are correctly recorded. I believe that all of the lives under the attached schedule are actively at work full time and physically performing all of the duties of their usual employment. Full time employment is defined as at least 30 hours per week at their regular place of employment. Furthermore, each participant has consented to the beneficiary details, the insurance coverage amount as per this master application; and the attached insurance schedule. They have each attested that they have not been absent from work in the past 90 days because of illness or injury; or have provided details that were deemed satisfactory for the purposes of the Company's underwriting guidelines. In addition, I understand and agree that:

- 1. The Insurance Schedule, the Consent to Life Insurance forms, and any Application Supplement shall form part of the application for life insurance.
- 2. Insurance under any policy issued as a result of this application will not be effective, and no insurance shall be provided prior to the later of the date the first premium is paid in full and the date the policy has been delivered; provided that at the time of delivery there has been no deterioration in the insurability of any person proposed for life insurance as stated in the application, since the date of the application.
- 3. Acceptance of the policy will, where permitted by law, constitute agreement to its terms and ratification of any changes specified by The Company in the policy, except that any change of amount, classification, plan, benefits or age at issue will be made only with the Owner's written consent.
- 4. Any person who knowingly and with intent to defraud any insurer: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.

OWNER/TAXPAYER CERTIFICATION - MUST BE COMPLETED

Under the penalties of perjury, I the Owner, certify that:

- 1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), **AND**
- 2. Check the applicable box:
 - I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, **AND**
 - The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, **AND**
- 3. I am a U.S. resident (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Signatures (Please read all of the above Declarations and Owner/Taxpayer Certification before signing this form.)

THIS APPLICATION FOR LIFE INSURANCE INCLUDES THE INSURANCE SCHEDULE OR CENSUS, CONSENT TO LIFE INSURANCE FORMS, APPLICATION SUPPLEMENT FOR INVESTMENT ALLOCATION AND INVESTOR SUITABILITY AND APPLICATION SUPPLEMENT - CUSTOMIZED SCHEDULE, IF APPLICABLE.

Signed at City, State	This	Day of	Year
X			
Witness	Owner's Name		
X	X		
Agent/Registered Representative, if other than Witness	Signature and Title of Authorized Officer		
X	X		



Simplified Application for Life Insurance
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Service Office:
 COLI Unit
 197 Clarendon Street
 Boston MA 02116-5010

- For individually underwritten small business life insurance.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured and/or Owner.

Proposed Life Insured

1. a) Name

First JOHN	Middle M.	Last DOE
----------------------	---------------------	--------------------

b) Date of Birth

month OCT	day 04	year 1967
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 c) Sex M F

d) Social Security/Tax ID Number

1	2	3	4	5	6	7	8	9
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e) Workplace Address

Address - Street No. & Name, Apt No., City, State, Zip code		
1999 MARCH STREET	ANYTOWN, ANYSTATE	12345

f) Place of Birth

ANYTOWN	USA
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 g) Driver's Information

License No.	1234567890	State	AS
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h) Residency Status U.S. Resident Other

i) Citizenship if other than U.S.

j) Name of Employer

Name of Employer	COMPANY PRESIDENT
------------------	--------------------------

k) Occupation/Title

Occupation	ABC COMPANY
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 l) Salary \$ **100,000**

Owner (Complete only if Owner is other than Proposed Life Insured)

2. a) Name of Owner

b) Date of Birth

month	day	year
-------	-----	------

 c) Relationship to Proposed Life Insured

d) Address

Address - Street No. & Name, Apt No., City, State, Zip code

e) Social Security/Tax ID Number

f) Residency Status U.S. Resident Other

g) Citizenship if other than U.S.

Employer, Business or Non Person Entity Ownership - Complete if applicable

3. I consent to the owner purchasing a maximum amount of \$ **500,000** life insurance on my life and that the coverage may continue after termination of my relationship with the owner.

Beneficiary Information - Subject to change by Owner

4. a) Primary

JAMES	M.	DOE
--------------	-----------	------------

 b) Relationship to Proposed Life Insured **SON**

c) Secondary

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 d) Relationship to Proposed Life Insured

For Employer or Business entity owners/beneficiaries, I acknowledge and consent to the above owner/beneficiary(s) having full rights and privileges to the insurance contract applied for.

Policy Details - For Variable Insurance Policies, complete required Application Supplement for Investment Allocation and Investor Suitability form.

5. Plan Name Corporate VUL Other _____

6. Face Amount (excluding Supplementary Benefits): \$ 500,000

7. Supplementary Benefits

Overloan Protection Rider

Return of Premium Death Benefit (with DB Option 1 only)

Increase Rate Yes _____ % No

Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %

Supplemental Face Amount (SFA) (Check only one option below.)

Level SFA of \$ _____ for life of the policy

Initial SFA of \$ _____ with Total Face Amount increasing by: _____ % or \$ _____ per year for _____ policy years (level thereafter)

Customized Level or Increasing Schedule (List by policy year. SFA decreases cannot be scheduled at issue.)
Please complete Application Supplement - Customized Schedule form.

Other _____

8. Death Benefit Option Option 1 (Face Amount) Option 2 (Face Amount plus Policy Value)

9. Loan Interest Rate Fixed Other _____ %

10. Life Insurance Qualification Test Guideline Premium (GPT) Cash Value Accumulation (CVAT)

Note: Elected test cannot be changed after the policy is issued. You may request an Illustration on both tests before making your election.

Premiums

11. Amount \$ 1,691.25 Frequency: Annual Other _____

Premium Notices and Correspondence

12. a) Send Premium Notices to: (Select one)

Owner Proposed Life Insured

Other: Name ABC COMPANY Street No. & Name, Apt No., City, State, Zip code 456 CENTER STREET, ANYTOWN, ANYSTATE 12346

b) Send Policy Correspondence to: (Select one)

Owner Proposed Life Insured Same as 12. a) above

Other: Name _____ Street No. & Name, Apt No., City, State, Zip code _____

Existing and Pending Insurance - Proposed Life Insured

13. a) Total insurance in force on the Proposed Life Insured \$ 200,000

b) Including this application, total insurance currently pending with all companies \$ 200,000

c) Of the above pending amount in 13. b), how much do you intend to accept? \$ 200,000

Existing Insurance - Owner Replacements

14. Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums due on the new policy or contract?

Yes No If **Yes**, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities.

Personal or Attending Physician

15. a) Name and Address of Personal or Attending Physician

Name - First, Middle, Last ARTHUR H. SMITH Address - Street No. & Name, Apt No., City, State, Zip code 123 MAIN STREET ANYTOWN, ANYSTATE 12347

b) Telephone No. (905) 123-8765 c) Date last consulted JANUARY 15, 2003

d) Reason for last consultation ANNUAL CHECK-UP

e) Results of last consultation _____

Personal Questions

16. a) Your Height (feet, inches) b) Your Weight (pounds)
- c) Have you had a loss of weight of more than 10 pounds within the past 12 months?
 No Yes - state how much and reason
17. a) Are you actively at full-time work and performing all the duties of your usual employment, at least 30 hours per week, 5 days per week at your regular place of employment? **If NO, please provide details below.** Yes No
- b) During the last 3 months, have you been absent from work because of illness or injury for 5 or more consecutive days? Yes No
- c) Have you used tobacco in any form within the last 12 months? Yes No
- d) Have you ever had or been treated for: Any disturbance of heart, lungs, kidneys or blood vessels; tumor or cancer, diabetes, elevated blood pressure; blood or nervous disorder; disorder of the stomach, intestine or liver; or accident? Yes No
- e) Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Yes No
- f) Have you ever been treated for alcohol or drug abuse? Yes No
- g) Have you had any operations, medical treatment or physical examination during the past 3 years? Yes No
- h) Have you ever had a request for life insurance declined, rated or issued other than as applied? Yes No
- i) Have you been prescribed any medications within the past 12 months? Yes No
- j) Do you engage in flying as a pilot or passenger on non-scheduled flight; or in any form of motor vehicle or power boat racing; or skin or scuba diving; sky diving/parachuting, hang gliding, mountain climbing or any other hazardous activities? **If Yes, state which activity(ies) and complete the appropriate sections of the Aviation Questionnaire form and/or Avocation Questionnaire form.** Yes No
- k) Have you been convicted of 2 or more moving violations within the last 2 years? Yes No
- l) Have you been convicted of driving while intoxicated or while otherwise impaired? Yes No

Details to any "Yes" answers and if "No" for 17. a). If more space is required, use the Medical Questions Continuation Sheet.

Question No.	Date	Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital
	mmm dd yyyy			

Special Requests

18. a) Special Policy Date b) Other

Telephone and/or Internet Transfer/Allocation Change Authorization

19. I understand and agree that:
- a) By checking one of the boxes below, I am authorizing The Company to accept telephone and Internet transfers and allocation changes. Telephone and Internet transfers and allocation changes will also be subject to the terms and conditions of the policy, and the administrative requirements of The Company.
- b) **The Company will honor telephone and Internet instructions from anyone who provides correct identifying information.** The Company, its agents or representatives of employees who act on its behalf will not be subject to any claim, liability, loss, expense or cost if acted on in good faith upon telephone or Internet instructions it reasonably believes to be genuine in reliance on this signed authorization.
- c) The Company, at its option alone and without prior or subsequent notice to the Owner(s), or any other person or representative of the Owner(s), may record all or part of any telephone conversation containing telephone transfer and/or allocation change instructions.
- d) All terms of the Authorization are binding upon the agents, heir and assignees of the Owner(s).
- e) This Telephone and Internet Transfer/Allocation Change Authorization will be effective until such time as (a) written revocation is received by The Company's Service Office, or (b) The Company discontinues this privilege, whichever occurs first.
- Please check (✓) ONLY one box:**
- I authorize The Company to accept telephone and Internet instructions from me or any co-owner.
- I authorize The Company to accept telephone and Internet instructions from me, any co-owner or our Registered Representative.

Declarations

The Proposed Life Insured and Owner declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of my knowledge and believe they are correctly recorded.

In addition, I understand and agree that:

- 1. The statements and answers in this application, which includes the Application Supplement for Investment Allocation and Investor Suitability form, the Application Supplement - Customized Schedule, if applicable, and any supplemental form relating to the health, avocation or lifestyle of the Proposed Life Insured, will become part of the insurance policy issued as a result of this application.
- 2. Insurance under any policy issued as a result of this application will not be effective, and no insurance shall be provided prior to the later of the date the first premium is paid in full and the date the policy has been delivered; provided that at the time of delivery there has been no deterioration in the insurability of any person proposed for life insurance as stated in the application, since the date of the application.
- 3. Acceptance of the policy will, where permitted by law, constitute agreement to its terms and ratification of any changes specified by The Company in the policy, except that any change of amount, classification, plan, benefits or age at issue will be made only with the Owner's written consent.
- 4. Any person who knowingly and with intent to defraud any insurer: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.

Authorizations and Owner/Taxpayer Certification

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured(s), authorize:

- 1. John Hancock Life Insurance Company (U.S.A.) (The Company) to obtain an investigative consumer report on me.
- 2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

In turn, The Company is free to disclose such information and any information developed during its evaluation of my application to:

- (a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me; (d) me; (e) any medical professional designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc.

This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

OWNER/TAXPAYER CERTIFICATION - MUST BE COMPLETED

Under the penalties of perjury, I the Owner, certify that:

- 1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), **AND**

2. Check the applicable box:

- I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, **AND**

- The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, **AND**

- 3. I am a U.S. resident (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Signatures (Please read all of the above Declarations, Authorizations and Certification before signing this form.)

Signed at City, State	This	Day of	Year
Signature of Agent/Registered Representative (as Witness) X		Signature of Proposed Life Insured X	
		Signature of Owner, if other than a Proposed Life Insured X	



GI Application for Life Insurance
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Service Office:
 COLI Unit
 197 Clarendon Street
 Boston MA 02116-5010

- For individually underwritten small business life insurance.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured and/or Owner.

Proposed Life Insured

1. a) Name

First JOHN	Middle M.	Last DOE
----------------------	---------------------	--------------------

b) Date of Birth

month OCT	day 04	year 1967
---------------------	------------------	---------------------

 c) Sex M F

d) Social Security/Tax ID Number

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

e) Workplace Address

Address - Street No. & Name, Apt No., City, State, Zip code 1999 MARCH STREET ANYTOWN, ANYSTATE 12345		
---	--	--

f) Place of Birth

ANYTOWN	USA
----------------	------------

 g) Driver's Information

License No. 1234567890	State AS
----------------------------------	--------------------

h) Residency Status U.S. Resident Other

i) Citizenship if other than U.S.

j) Name of Employer

Name of Employer COMPANY PRESIDENT
--

k) Occupation/Title

Occupation ABC COMPANY

 l) Salary \$

200,000

Owner (Complete only if Owner is other than Proposed Life Insured)

2. a) Name of Owner

ABC COMPANY

b) Date of Birth

month	day	year
-------	-----	------

 c) Relationship to Proposed Life Insured

EMPLOYER

d) Address

Address - Street No. & Name, Apt No., City, State, Zip code 456 CENTER STREET, ANYTOWN, ANYSTATE 12346		
--	--	--

e) Social Security/Tax ID Number

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

f) Residency Status U.S. Resident Other

g) Citizenship if other than U.S.

Employer, Business or Non Person Entity Ownership - Complete if applicable

3. I consent to the owner purchasing a maximum amount of \$

500,000

 life insurance on my life and that the coverage may continue after termination of my relationship with the owner.

Beneficiary Information - Subject to change by Owner

4. a) Primary

JAMES	M.	DOE
--------------	-----------	------------

 b) Relationship to Proposed Life Insured

SON

c) Secondary

--

 d) Relationship to Proposed Life Insured

--

For Employer or Business entity owners/beneficiaries, I acknowledge and consent to the above owner/beneficiary(s) having full rights and privileges to the insurance contract applied for.

Policy Details - For Variable Insurance Policies, complete required Application Supplement for Investment Allocation and Investor Suitability form.

5. Plan Name Corporate VUL Other _____

6. Face Amount (excluding Supplementary Benefits): \$ 500,000

7. Supplementary Benefits

Overloan Protection Rider

Return of Premium Death Benefit (with DB Option 1 only)
Increase Rate Yes _____ % No

Percentage of Premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %

Supplemental Face Amount (SFA) (Check only one option below.)

Level SFA of \$ _____ for life of the policy

Initial SFA of \$ _____ with Total Face Amount increasing by: _____ % or \$ _____ per year for _____ policy years (level thereafter)

Customized Level or Increasing Schedule (List by policy year. SFA decreases cannot be scheduled at issue. Please complete Application Supplement - Customized Schedule form.)

Other _____

8. Death Benefit Option Option 1 (Face Amount) Option 2 (Face Amount plus Policy Value)

9. Loan Interest Rate Fixed Other _____ %

10. Life Insurance Qualification Test Guideline Premium (GPT) Cash Value Accumulation (CVAT)

Note: Elected test cannot be changed after the policy is issued. You may request an Illustration on both tests before making your election.

Premiums

11. Amount \$ 1,691.25 Frequency: Annual Other _____

Premium Notices and Correspondence

12. a) Send Premium Notices to: (Select one)

Owner Proposed Life Insured

Other: Name _____

Street No. & Name, Apt No., City, State, Zip code _____

b) Send Policy Correspondence to: (Select one)

Owner Proposed Life Insured Same as 12. a) above

Other: Name _____

Street No. & Name, Apt No., City, State, Zip code _____

Existing and Pending Insurance - Proposed Life Insured

13. a) Total insurance in force on the Proposed Life Insured \$ 200,000

b) Including this application, total insurance currently pending with all companies \$ 200,000

c) Of the above pending amount in 13. b), how much do you intend to accept? \$ 200,000

Existing Insurance - Owner Replacements

14. Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums due on the new policy or contract?

Yes No If **Yes**, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities.

Actively at Work

15. Are you actively at full time work and performing all the duties of your usual employment at least 30 hours per week, 5 days a week at your regular place of employment? If **No**, give details below. Yes No
16. During the last three months, have you been absent from work due to illness or injury for more than 5 consecutive work days? If **Yes**, give details below. Yes No

Smoking Question

17. During the last twelve months, have you smoked any cigarettes? Yes No

Personal or Attending Physician

18. a) Name and Address of Personal or Attending Physician

Name - First, Middle, Last

ARTHUR H. SMITH

Address - Street No. & Name, Apt No., City, State, Zip code

123 MAIN STREET ANYTOWN, ANYSTATE 12347

- b) Telephone No.

(905) 123-8765

- c) Date last consulted

JANUARY 15, 2003

- d) Reason for last consultation.

ANNUAL CHECK-UP

Special Requests

19. a) Special Policy Date

- b) Other

Telephone and/or Internet Transfer/Allocation Change Authorization

20. I understand and agree that:

- a) By checking one of the boxes below, I am authorizing The Company to accept telephone and Internet transfers and allocation changes. Telephone and Internet transfers and allocation changes will also be subject to the terms and conditions of the policy, and the administrative requirements of The Company.
- b) **The Company will honor telephone and Internet instructions from anyone who provides correct identifying information.** The Company, its agents or representatives of employees who act on its behalf will not be subject to any claim, liability, loss, expense or cost if acted on in good faith upon telephone or Internet instructions it reasonably believes to be genuine in reliance on this signed authorization.
- c) The Company, at its option alone and without prior or subsequent notice to the Owner(s), or any other person or representative of the Owner(s), may record all or part of any telephone conversation containing telephone transfer and/or allocation change instructions.

- d) All terms of the Authorization are binding upon the agents, heir and assignees of the Owner(s).
- e) This Telephone and Internet Transfer/Allocation Change Authorization will be effective until such time as (a) written revocation is received by The Company's Service Office, or (b) The Company discontinues this privilege, whichever occurs first.

Please check (✓) ONLY one box:

- I authorize The Company to accept telephone and Internet instructions from me or any co-owner.
- I authorize The Company to accept telephone and Internet instructions from me, any co-owner or our Registered Representative.

Declarations

The Proposed Life Insured and Owner declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of my knowledge and believe they are correctly recorded.

In addition, I understand and agree that:

- 1. The statements and answers in this application, which includes the Application Supplement for Investment Allocation and Investor Suitability form, the Application Supplement - Customized Schedule, if applicable, and any supplemental form relating to the health, avocation or lifestyle of the Proposed Life Insured, will become part of the insurance policy issued as a result of this application.
- 2. Insurance under any policy issued as a result of this application will not be effective, and no insurance shall be provided prior to the later of the date the first premium is paid in full and the date the policy has been delivered; provided that at the time of delivery there has been no deterioration in the insurability of any person proposed for life insurance as stated in the application, since the date of the application.
- 3. Acceptance of the policy will, where permitted by law, constitute agreement to its terms and ratification of any changes specified by The Company in the policy, except that any change of amount, classification, plan, benefits or age at issue will be made only with the Owner's written consent.
- 4. Any person who knowingly and with intent to defraud any insurer: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.

Authorizations and Owner/Taxpayer Certification

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured(s), authorize:

- 1. John Hancock Life Insurance Company (U.S.A.) (The Company) to obtain an investigative consumer report on me.
- 2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

In turn, The Company is free to disclose such information and any information developed during its evaluation of my application to:

- (a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me; (d) me; (e) any medical professional designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc.

This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

OWNER/TAXPAYER CERTIFICATION - MUST BE COMPLETED

Under the penalties of perjury, I the Owner, certify that:

- 1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), **AND**

2. Check the applicable box:

- I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, **AND**

- The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, **AND**

- 3. I am a U.S. resident (including a U.S. resident alien).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Signatures (Please read all of the above Declarations, Authorizations and Certification before signing this form.)

Signed at City, State	This	Day of	Year
Signature of Agent/Registered Representative (as Witness) X		Signature of Proposed Life Insured X	
		Signature of Owner, if other than a Proposed Life Insured X	



Simplified Consent to Life Insurance
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Service Office:
 COLI Unit
 197 Clarendon Street
 Boston MA 02116-5010

- This form is part of the Master COLI Application for Life Insurance.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

Consent

1. I, (Full name of Proposed Life Insured), consent to (The Owner), purchasing a maximum amount of \$ life insurance on my life and that the coverage may continue after termination of my current employment with: Employer

2. a) Beneficiary (if other than the Owner) First Middle Last
 b) Relationship to Proposed Life Insured(s)

I acknowledge and consent to the above beneficiary(s) and owners having full rights and privileges to the insurance contract applied for.

3. a) Date of Birth month day year
 b) Sex M F
 c) Social Security/Tax ID Number
 d) Residency Status U.S. Resident Other
 e) Citizenship if other than U.S.
 f) Workplace Address Address - Street No. & Name, Apt No., City, State, Zip code
 g) Occupation/Title
 h) Salary \$

Personal or Attending Physician

4. a) Name and Address of Personal or Attending Physician
 Name - First, Middle, Last Address - Street No. & Name, Apt No., City, State, Zip code
 b) Telephone No.
 c) Date last consulted
 d) Reason for last consultation
 e) Results of last consultation

Personal Questions

5. a) Your Height (feet, inches) b) Your Weight (pounds)
 c) Have you had a loss of weight of more than 10 pounds within the past 12 months?
 No Yes - state how much and reason
 6. a) Are you actively at full-time work and performing all the duties of your usual employment, at least 30 hours per week, 5 days per week at your regular place of employment? **If NO, please provide details on page 2.** Yes No
 b) During the last 3 months, have you been absent from work because of illness or injury for 5 or more consecutive days? Yes No
 c) Have you used tobacco in any form within the last 12 months? Yes No
 d) Have you ever had or been treated for: Any disturbance of heart, lungs, kidneys or blood vessels; tumor or cancer, diabetes, elevated blood pressure; blood or nervous disorder; disorder of the stomach, intestine or liver; or accident? Yes No
 e) Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)? Yes No
 f) Have you ever been treated for alcohol or drug abuse? Yes No

Personal Questions - continued

- 6. g) Have you had any operations, medical treatment or physical examination during the past 3 years? Yes No
- h) Have you ever had a request for life insurance declined, rated or issued other than as applied? Yes No
- i) Have you been prescribed any medications within the past 12 months? Yes No
- j) Do you engage in flying as a pilot or passenger on non-scheduled flight; or in any form of motor vehicle or power boat racing; or skin or scuba diving; sky diving/parachuting, hang gliding, mountain climbing or any other hazardous activities? Yes No
If **Yes**, state which activity(ies) and complete the appropriate sections of the Aviation Questionnaire form and/or Avocation Questionnaire form.
- k) Have you committed 2 or more moving violations within the last 2 years? Yes No

Details to any "Yes" answers and if "No" for 6. a). If more space is required, use the Medical Questions Continuation Sheet.

Question No.	Date	Reason and treatment given	Duration of Condition	Name, Address and Telephone Number of Attending Physician and Hospital
	mmm dd yyyy			

Authorization

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured(s), authorize:

- John Hancock Life Insurance Company (U.S.A.) (The Company) to obtain an investigative consumer report on me.
- Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.

In turn, The Company is free to disclose such information and any information developed during its evaluation of my/our application to:

- (a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me; (d) me; (e) any medical professional designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc.

This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

Signatures

Any person who knowingly and with intent to defraud any insurer: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.

I agree that the above statements and answers are complete and true to the best of my knowledge and belief. I understand that this Consent for insurance on my life shall form part of the Master COLI Application to The Company.

Signed at City, State	This	Day of	Year
Signature of Agent/Registered Representative (as Witness)	Signature of Proposed Life Insured		
x	x		



GI Consent to Life Insurance

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as *The Company*)

Service Office:

COLI Unit
197 Clarendon Street
Boston MA 02116-5010

- This form is part of the Master COLI Application for Life Insurance.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

Consent

1. I, (Full name of Proposed Life Insured), consent to (The Owner), purchasing a maximum amount of \$ life insurance on my life and that the coverage may continue after termination of my current employment with: Employer

2. a) Beneficiary (if other than the Owner)

b) Relationship to Proposed Life Insured(s)

I acknowledge and consent to the above beneficiary(s) and owners having full rights and privileges to the insurance coverage applied for.

3. a) Date of Birth month day year

b) Sex M F

c) Social Security/Tax ID Number

d) Residency Status U.S. Resident Other

e) Citizenship if other than U.S.

f) Workplace Address Address - Street No. & Name, Apt No., City, State, Zip code

g) Occupation/Title

h) Salary \$

- i) Are you actively at full time work and performing all the duties of your usual employment at least 30 hours per week, 5 days a week at your regular place of employment? If **No**, give details below. Yes No
- j) During the last three months, have you been absent from work due to illness or injury for more than 5 consecutive work days? If **Yes**, give details below. Yes No

- k) During the last twelve months, have you smoked any cigarettes? Yes No

Signature

I declare that the above statements and answers are complete and true to the best of my knowledge and belief. I understand that this consent for insurance on my life shall form part of the Master COLI Application for Life Insurance.

Signed at City, State This Day of Year

Signature of Proposed Life Insured



Insurance Schedule
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Service Office:
 COLI Unit
 197 Clarendon Street
 Boston MA 02116-5010

- This form is part of the Master COLI Application for Life Insurance.
- Type or print using black ink. Any changes must be initialed by the Owner's Authorized Officer.
- Use additional forms if required.

Insurance Schedule for ABC COMPANY (Name of Owner)

Social Security/ Tax ID No.	Name First, Middle, Last	Date of Birth			Insurance Age	Sex M/F	Smoker Y/N	Initial Base Face Amount	Supplemental Face Amount *	Total Face Amount	Annual Premium
		mm	dd	yy							
123-45-6789	JOHN M. DOE	02	15	62	39	M	N	\$ 200,000	\$	\$ 200,000	\$
111-44-3213	MARY E. DOE	04	19	63	38	F	N	\$ 200,000	\$	\$ 200,000	\$
222-43-4414	JAMES A. SMITH	11	17	55	45	M	N	\$ 200,000	\$	\$ 200,000	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$
								\$	\$	\$	\$

* Show "M" to denote that SFA matches the option selected on the Master COLI Application. Show "C" to denote that SFA matches the Application Supplement - Customized Schedule.

Signature
 This Insurance Schedule, the Master COLI Application for Life Insurance, Consent to Life Insurance forms and any Application Supplement shall constitute the applications for coverage insuring the lives of each Proposed Life Insured. The above information is complete and true to the best of my knowledge and belief.

Signed at City, State This Day of Year

Signature and Title of Owner's Authorized Officer



Application Supplement - Customized Schedule

John Hancock Life Insurance Company (U.S.A.)

(hereinafter referred to as *The Company*)

Service Office:

COLI Unit
197 Clarendon Street
Boston MA 02116-5010

- Use with COLI Master Application for Life Insurance.
- Print and use black ink.

Proposed Life Insured

1. a) Proposed Lives as per the Insurance Schedule or Census and Consent to Life Insurance forms.

OR

b) Name

First	JOHN	M.	Middle	DOE	Last
Name of Owner	ABC COMPANY				

Supplementary Benefit - Customized Schedule

2. Supplemental Face Amount (SFA) (Check only one option below.)

- Level SFA of \$ _____ for life of the policy
- Initial SFA of \$ _____ with Total Face Amount increasing by: _____ % or \$ _____ per year for _____ policy years (level thereafter)
- Customized Schedule (see below)

Customized Schedule for Increasing Supplemental Face Amount - Amount may not decrease from year to year.

Policy Year(s)	Amount	Policy Year(s)	Amount
1 to 10	\$ 100,000 (1)	to	\$ (19)
11 to 99	\$ 150,000 (2)	to	\$ (20)
to	\$ (3)	to	\$ (21)
to	\$ (4)	to	\$ (22)
to	\$ (5)	to	\$ (23)
to	\$ (6)	to	\$ (24)
to	\$ (7)	to	\$ (25)
to	\$ (8)	to	\$ (26)
to	\$ (9)	to	\$ (27)
to	\$ (10)	to	\$ (28)
to	\$ (11)	to	\$ (29)
to	\$ (12)	to	\$ (30)
to	\$ (13)	to	\$ (31)
to	\$ (14)	to	\$ (32)
to	\$ (15)	to	\$ (33)
to	\$ (16)	to	\$ (34)
to	\$ (17)	to	\$ (35)
to	\$ (18)	to	\$ (36)

If additional space is required, attach an additional copy of this form.

SERFF Tracking Number: MANU-125742058 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 40055
Company Tracking Number: CP4000/01/02/03/04/05/06 (09/2008)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: CP4000/01/02/03/04/05/06 (09/2008)
Project Name/Number: CP4000/01/02/03/04/05/06 (09/2008)/CP4000/01/02/03/04/05/06 (09/2008)

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MANU-125742058 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 40055
Company Tracking Number: CP4000/01/02/03/04/05/06 (09/2008)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: CP4000/01/02/03/04/05/06 (09/2008)
Project Name/Number: CP4000/01/02/03/04/05/06 (09/2008)/CP4000/01/02/03/04/05/06 (09/2008)

Supporting Document Schedules

Satisfied -Name: Certification/Notice	Review Status:	07/21/2008
Comments:		
Attachment: flesch ar.pdf		
Satisfied -Name: Cover Letter	Review Status:	08/25/2008
Comments:		
Attachment: letter ar.pdf		
Satisfied -Name: Statement of Variability	Review Status:	08/25/2008
Comments:		
Attachment: SOV US jhusa.pdf		

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)

**FLESCH SCORE CERTIFICATE
FOR THE STATE OF ARKANSAS**

I, Helene Landow, an officer of JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.), hereby certify that the forms listed below has the following readability scores as calculated by the Flesch Reading Ease Test, and that these forms meet the requirements of your readability legislation.

FORM NUMBER	READABILITY SCORE
CP4000US (09/2008)	40*
CP4001US (09/2008)	41
CP4002US (09/2008)	40*
CP4003US (09/2008)	47
CP4004US (09/2008)	70
CP4005US (09/2008)	50
CP4006US (09/2008)	59

*Joint score for application and policy combined.

August 21, 2008
Date



Helene Landow, FLMI, ACP
Director, Contracts and Compliance

John Hancock Life Insurance Company (U.S.A.)

Contracts and Compliance
P.O. Box 600
Buffalo, NY 14201-0600
Tel.: 416-852-7906
Fax: 416-926-3121
Email: jacqueline_lau@jhancock.com



N.A.I.C. # 65838
SERFF Tracking # MANU-125742058

Jacqueline Lau
Contract Analyst

August 25, 2008

Hon. Commissioner of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, Arkansas 72201-1904

Attention: Linda Bird

Dear Ms. Bird:

INDIVIDUAL LIFE

Application Form CP4000US (09/2008) - Master COLI Application for Life Insurance
Application Form CP4001US (09/2008) - Simplified Application for Life Insurance
Application Form CP4002US (09/2008) - GI Application for Life Insurance
Application Form CP4003US (09/2008) - Simplified Consent to Life Insurance
Application Form CP4004US (09/2008) - GI Consent to Life Insurance
Application Form CP4005US (09/2008) - Insurance Schedule
Application Form CP4006US (09/2008) - Application Supplement – Customized Schedule

We are submitting the above new application forms for your approval. These forms will be used with state approved Universal Life and Variable Life policies in the corporate-owned and bank-owned individual life insurance markets. These new forms do not replace any currently approved forms and will be available electronically to print locally without any change in the pre-formatted content.

No part of this filing contains any unusual or controversial items that deviate from normal company or industry standards.

CP4000US (09/2008), Master COLI Application for Life Insurance, will be used on multi-life cases where the underwriting criteria for the insured is based primarily on actively at work and smoking status. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4001US (09/2008), Simplified Application for Life Insurance, will be used with cases of 5 to 150 participants and when limited evidence of insurability is required. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4002US (09/2008), GI Application for Life Insurance, will be used with cases of 10 or more participants and when the selection criteria is based on actively at work on a full-time basis and smoking status. The Policy Details section is shown as variable information in [brackets] to accommodate future changes to the plan/benefit options.

CP4003US (09/2008), Simplified Consent to Life Insurance, will be used to obtain consent to be insured and to ask simplified health questions for each individual. This form will be used in conjunction with the Master COLI application and insurance schedule.

CP4004US (09/2008), GI Consent to Life Insurance, will be used to obtain consent to be insured and ask about activity at work and smoking status for each Proposed Life Insured. This form will be used in conjunction with the Master COLI application and insurance schedule.

CP4005US (09/2008), Insurance Schedule, will be used with the Master COLI application to list the data for coverage of individuals to be insured.

CP4006US (09/2008), Application Supplement – Customized Schedule, if applicable, will be used with the Master COLI Application, Simplified Application and GI Application for Life Insurance forms, to list data for scheduled custom or increasing Supplemental Face Amounts.

The Service Office Address wherever shown on the submitted form is being filed as variable information [shown in brackets] in case of future change.

We trust the forms are acceptable to you and look forward to your state's approval in the usual manner. If you have any questions or concerns, please contact me at 416-852-7906 (collect) or via e-mail at jacqueline_lau@jhancock.com.

Sincerely,



Jacqueline Lau
Contract Analyst

Enclosures: Statement of Variability
Filing Fee Form (EFT)
Flesch Score Certificate

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)

STATEMENT OF VARIABILITY

JULY 23, 2008

MASTER COLI APPLICATION FOR LIFE INSURANCE

FORM CP4000US (09/2008)

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.
Policy Details #3 to 4	Page 1	The Policy Details section is [bracketed] to accommodate future changes. Plan/Product name, Supplementary Benefits, Supplementary Face Amount and Other, all vary based on issue specifications/availability at time of application. Current selections will always appear on the form.

SIMPLIFIED APPLICATION FOR LIFE INSURANCE

FORM CP4001US (09/2008)

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.
Policy Details #5 to 7	Page 2	The Policy Details section is [bracketed] to accommodate future changes. Plan/Product name, Supplementary Benefits, Supplementary Face Amount and Other, all vary based on issue specifications/availability at time of application. Current selections will always appear on the form.

GI APPLICATION FOR LIFE INSURANCE**FORM CP4002US (09/2008)**

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.
Policy Details #5 to 7	Page 2	The Policy Details section is [bracketed] to accommodate future changes. Plan/Product name, Supplementary Benefits, Supplementary Face Amount and Other, all vary based on issue specifications/availability at time of application. Current selections will always appear on the form.

SIMPLIFIED CONSENT TO LIFE INSURANCE**FORM CP4003US (09/2008)**

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.

GI CONSENT TO LIFE INSURANCE**FORM CP4004US (09/2008)**

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.

INSURANCE SCHEDULE**FORM CP4005US (09/2008)**

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.

APPLICATION SUPPLEMENT – CUSTOMIZED SCHEDULE**FORM CP4006US (09/2008)**

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current address will always appear on the form.
Supplementary Benefit #2	Page 1	The Supplementary Benefit – Customized Schedule section is [bracketed] to accommodate future changes. Supplementary Face Amount vary based on issue specifications/availability at time of application. Current selection will always appear on the form.