

SERFF Tracking Number: MULF-125419947 State: Arkansas  
 Filing Company: John Hancock Life Insurance Company State Tracking Number: 37807  
 Company Tracking Number:  
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
 Product Name: Long term care insurance- CCII 2008  
 Project Name/Number: CCII Enhanced 2008/

## Filing at a Glance

Company: John Hancock Life Insurance Company

Product Name: Long term care insurance- CCII SERFF Tr Num: MULF-125419947 State: ArkansasLH  
 2008

TOI: LTC03I Individual Long Term Care

SERFF Status: Closed

State Tr Num: 37807

Sub-TOI: LTC03I.001 Qualified

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Harris Shearer

Authors: Pat Hamlett, Joanne  
 Witham, Richard Famiglietti

Disposition Date: 08/21/2008

Date Submitted: 01/08/2008

Disposition Status: Approved

Implementation Date Requested: 04/01/2008

Implementation Date:

State Filing Description:

## General Information

Project Name: CCII Enhanced 2008

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/21/2008

State Status Changed: 08/21/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We enclose copies of the forms listed above for your review and approval. A description of these forms is found below. These forms are new and will replace any prior versions that we currently have on file with your Department. These forms will be used with our Custom Care II policy form LTC-03 AR approved by your Department on 10/16/03. And Leading Edge policy form LTC-06 AR approved by your Department on 1/8/07. The effective date for the use of these forms will be April 1, 2008 or immediately following approval if later. The purpose of this filing is fourfold:

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Addition of Consumer Protection Provisions to our Portfolios – We would like to add the following consumer protection provisions to our currently marketed product portfolio:

- a new Alternate Services Benefit.
- an enhancement to our Time of Payment of Claims provision.
- the addition of a new Independent Third Party Review provision.
- for Custom Care II (LTC-03 AR) only, we are also including a new enhancement which allows individuals to increase or decrease their coverage which is identical to our Leading Edge policy.

These features are included in endorsement Forms LTC-CPP1 1/08 for policy form LTC-03 AR and LTC-CPP2 1/08 for policy form LTC-06 AR. We have also revised the outlines of coverage for both policy forms, OCLTC-03 1/08 and OCLTC07-2 1/08.

Addition of Automatic Inflation Coverage to our Custom Care II Portfolio - We are also including the Automatic Inflation (LTC-2CPI/GIO 1/08) to be used with our LTC-03 AR policy form, which is identical to our already approved version LTC-CPI/GIO 6/07 (approved by your department 12/3/07), with the exception of the "Important Notice" section. As we are filing this new option, we would like to inform you that we will discontinue offering the 5/3 inflation option (LTC-3COMP 9/03), approved by your department on 10/16/06. Application forms CC2APP08 AR, CC2USAA08 AR, CC2MGTI08 AR and CC2SGRP08 AR and the outline of coverage OCLTC-03 1/08 reflect this additional options.

2006 NAIC LTC Model Updates - In accordance with the 2006 NAIC Long Term Care Model changes we are submitting new and revised forms. We have reviewed the changes and found that our portfolios only need to be updated in the areas relating to downgrades and contingent benefit for policies with limited payment options. The downgrade provision is included in submitted endorsement form LTC-CPP1 1/08 for LTC-03 AR. Please note the downgrade provision is already included in policy form LTC-06 AR so no addition is required to this form. We are submitting for approval the Contingent Nonforfeiture for policies with Limited Payment options LTC-LIMCNF 9/07, the Personal Worksheet (agent) LTC-PWK 1/08, the Personal Worksheet (direct) LTC-PWKDM 1/08, the Suitability Information Sheet LTC-SUIT 9/07 and Rate Increase Disclosure LTC-RII 9/07 that will be used with both policy forms.

Submission of Supportive Actuarial Material - As we have enhanced the policy benefits through the LTC-CPP1 1/08 endorsement, adjusted rates and the addition of the Automatic Inflation option to our policy LTC-03 AR, enclosed is the Actuarial Memorandum that reflects these changes. In addition, we are including an amendment to the LTC-06 AR to

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reflect the LTC-CPP2 1/08 endorsement, with no change in rates.

From time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/printed via website technology. Variable information is enclosed by brackets “[ ]” please see Appendix A for Statement of Variability.

## Company and Contact

### Filing Contact Information

Richard Famiglietti, Sr. Contract Consultant rfamiglietti@jhancock.com  
 200 Berkeley Street (617) 572-1997 [Phone]  
 Boston, MA 02117 (617) 572-0399[FAX]

### Filing Company Information

John Hancock Life Insurance Company CoCode: 65099 State of Domicile: Massachusetts  
 200 Berkeley Street Group Code: 356 Company Type: Long Term Care Insurance

P O Box 111  
 Boston, MA 02117  
 (617) 572-5000 ext. [Phone]

Group Name:  
 FEIN Number: 04-1414660  
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State ID Number:

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? Yes  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company	\$50.00	01/08/2008	17391438

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Harris Shearer	08/21/2008	08/21/2008

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Automatic Inflation	Form	Joanne Witham	01/18/2008	01/18/2008
CC2 En. Application	Form	Joanne Witham	01/18/2008	01/18/2008
CC2 En. USAA App.	Form	Joanne Witham	01/18/2008	01/18/2008
Corp Sol Application	Form	Joanne Witham	01/18/2008	01/18/2008
Sponsored Group Applicaiton	Form	Joanne Witham	01/18/2008	01/18/2008
CC2 Enhanced OOC	Form	Joanne Witham	01/18/2008	01/18/2008
Guaranteed Purchase Option	Form	Joanne Witham	01/18/2008	01/18/2008
Health - Actuarial Justification	Supporting Document	Joanne Witham	01/18/2008	01/18/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
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Status Note To Reviewer Joanne Witham 07/22/2008 07/22/2008

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## Disposition

Disposition Date: 08/21/2008

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		Yes
Supporting Document (revised)	Health - Actuarial Justification		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter		Yes
Form	Con. Protection Endorsement		Yes
Form (revised)	Automatic Inflation		Yes
Form	Automatic Inflation		No
Form (revised)	CC2 En. Application		Yes
Form	CC2 En. Application		No
Form (revised)	CC2 En USAA App.		Yes
Form	CC2 En USAA App.		No
Form (revised)	Corp Sol Application		Yes
Form	Corp Sol Application		No
Form (revised)	Sponsored Group Applicaiton		Yes
Form	Sponsored Group Applicaiton		No
Form (revised)	CC2 Enhanced OOC		Yes
Form	CC2 Enhanced OOC		No
Form	LE Con. Protection Endorsement		Yes
Form	LE Outline of Coverage		Yes
Form	LPO Contingent NF		Yes
Form	Suitability Information Sheet		Yes
Form	Personal Worksheet		Yes
Form	DM Personal Worksheet		Yes
Form	Rate Increase Disclosure		Yes
Form	Guaranteed Purchase Option		Yes

*SERFF Tracking Number:*      *MULF-125419947*                      *State:*                      *Arkansas*  
*Filing Company:*              *John Hancock Life Insurance Company*              *State Tracking Number:*      *37807*  
*Company Tracking Number:*  
*TOI:*                      *LTC03I Individual Long Term Care*              *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *Long term care insurance- CCII 2008*  
*Project Name/Number:*      *CCII Enhanced 2008/*

**Note To Reviewer**

**Created By:**

Joanne Witham on 07/22/2008 09:15 AM

**Subject:**

Status

**Comments:**

Hi,  
Could you please provide a status on this submission?

Thank you.

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 Product Name: Long term care insurance- CCII 2008  
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**Amendment Letter**

Amendment Date:  
 Submitted Date: 01/18/2008

**Comments:**

On 1/8/2008 we submitted to you Department a filing for review of Endorsements and Forms for our Policy Form LTC-03 AR and LTC-06 AR. We would like to amend this filing. Since the submission we have made a revision to the title of the endorsement LTC-2CPI/GIO 1/08 from "Automatic Inflation Coverage and Guaranteed Increase Option" to "CPI Compound Inflation and Guaranteed Increase Option". This change also affects application forms CC2APP08 AR, CC2APPUSAA08 AR, CC2MGTI08 AR and CC2SGRP08 AR and the outline of coverage OCLTC03 1/08. Also, we are submitting an additional form for review, form LTC-GPO 1/08, to replace form LTC-GPO 9/03 previously approved by your department on 10/16/03. This form has been revised to include reference to the CPI Compound Inflation and will continue to be use with our Custom Care II Enhanced policy (LTC-03 AR).

In addition, we have revised the actuarial memorandum for policy form LTC-03 AR to reflect the changes outlined above.

We apologize for any inconvenience this may have caused.  
 Thank you for your time and consideration in this matter.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LTC-2CPI/GIO	Policy/Contr act/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Automatic Inflation	Initial				0	2CPI_GIO_C CII.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action	Previous Filing #	Replaced Form #	Readability Score	Attachments
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SERFF Tracking Number: MULF-125419947

State: Arkansas

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Company Tracking Number:

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

Product Name: Long term care insurance- CCII 2008

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**Other**

CC2APP08	Application/ECC2 En.	Initial		0	CC2APP08_A
AR	nrollment Application Form				R_v2.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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CC2APPUS	Application/ECC2 En	Initial		0	CC2APPUSA
AA08 AR	nrollment USAA App. Form				A08_AR_v2.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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CC2MGTI08	Application/ECorp Sol	Initial		0	cc2mgti08_A
AR	nrollment Application Form				R_v2.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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CC2SGRP0	Application/ESponsored	Initial		0	cc2sgrp08_A
8 AR	nrollment Group Application Form				R_V2.pdf

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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CC2	Outline of	CC2	Initial		0	CC2E_OOC_
Enhanced	Coverage	Enhanced				08_1_16.pdf
OOC		OOC				

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
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LTC-GPO Policy/Contr Guaranteed Initial 0 LTC\_GPO\_1\_  
1/08 act/Fraternal Purchase 08.pdf  
Certificate: Option  
Amendment,  
Insert  
Page,  
Endorsemen  
t or Rider

SERFF Tracking Number: MULF-125419947

State: Arkansas

Filing Company: John Hancock Life Insurance Company

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Company Tracking Number:

TOI: LTC03I Individual Long Term Care

Sub-TOI: LTC03I.001 Qualified

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**Supporting Document Schedule Item Changes:**

**Satisfied -Name: Health - Actuarial Justification**

Comment:

Addendum to Actuarial Memo for form LTC-06 AR.pdf

AR CCII08 Filing v2.pdf

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## Form Schedule

Lead Form Number: LTC-CPP1

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LTC-CPP1	Policy/Cont	Con. Protection ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	LTC- CPP1_FINAL. pdf
	LTC- 2CPI/GIO	Policy/Cont	Automatic Inflation ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0	2CPI_GIO_C CII.pdf
	CC2APP08 AR	Application/	CC2 En. Application Enrollment Form	Initial		0	CC2APP08_A R_v2.pdf
	CC2APPU SAA08 AR	Application/	CC2 En USAA App. Enrollment Form	Initial		0	CC2APPUSA A08_AR_v2.p df
	CC2MGTI0 8 AR	Application/	Corp Sol Application Enrollment Form	Initial		0	cc2mgti08_A R_v2.pdf
	CC2SGRP 08 AR	Application/	Sponsored Group Enrollment Applicaiton Form	Initial		0	cc2sgrp08_A R_V2.pdf
	CC2 Enhanced	Outline of	CC2 Enhanced OOC Coverage	Initial		0	CC2E_OOC_ 08_1_16.pdf

SERFF Tracking Number: MULF-125419947 State: Arkansas  
 Filing Company: John Hancock Life Insurance Company State Tracking Number: 37807  
 Company Tracking Number:  
 TOI: LTC031 Individual Long Term Care Sub-TOI: LTC031.001 Qualified  
 Product Name: Long term care insurance- CCII 2008  
 Project Name/Number: CCII Enhanced 2008/

OOO

LE LTC- CPP2	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0	LTC- CPP2_FINAL. pdf	
LE OOC	Outline of Coverage	LE Outline of Coverage	Initial	0	ocltc07- 2_1_08.pdf
LTC- LIMCNF	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	LPO Contingent NF	Initial	0	limpay9_07.p df
LTC-SUIT 9/07	Other Suitability Information Sheet	Initial	0	Itcsuit_9_07.p df	
LTC-PWK 1/08	Other Personal Worksheet	Initial	0	ltpwk_2008. pdf	
LTC- PWKDM 1/08	Other DM Personal Worksheet	Initial	0	ltpwkdm_20 08.pdf	
LTC-RII 9/07	Other Rate Increase Disclosure	Initial	0	rateincrease_ 9_07.pdf	
LTC-GPO 1/08	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme	Guaranteed Purchase Option	Initial	0	LTC_GPO_1_ 08.pdf

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nt or Rider





## John Hancock Life Insurance Company

### Additional Consumer Protection Provisions

This Endorsement is made part of and should be attached to Your Policy. It is subject to all the provisions, conditions and limitations of the Policy unless otherwise provided below.

1. The following provision is added to the end of the YOUR LONG-TERM CARE BENEFITS section of Your Policy.

#### **Alternate Services Benefit**

The Alternate Services Benefit may cover long-term care services not expressly covered by the Policy so long as all the requirements of this provision are met.

We will consider paying actual charges for alternate services under the Alternate Services Benefit only if: We determine You are eligible for benefits under this Policy, and the alternate services are:

- an alternative to Long-Term Care Services which You would otherwise require, that is less expensive than the amount We would otherwise pay for such Long-Term Care Services; and
- medical or non-medical professional or personal care services to assist You in the Activities of Daily Living or to provide supervision needed because of Your Cognitive Impairment; and
- necessary for You based upon Your medical status, current and future care plans, and suitability and effectiveness of care; and
- included in Your Plan of Care; and
- agreed upon by You and Us.

If We determine that You are eligible for the Alternate Services Benefit, the alternate services will be described in an alternate services agreement that is mutually agreed to in writing by You and Us. Such agreement will specify the maximum amount that We will reimburse for such services. We will only pay for alternate services received on or after the effective date of the alternate services agreement. In addition, Your Policy must be in effect when the charges for alternate services are incurred.

Any benefits paid under this provision will reduce Your Policy Limit. Days for which You receive alternate services on or after the effective date of the alternate services agreement will count toward the Elimination Period. We will not pay this benefit until Your Elimination Period has been satisfied.

The Alternate Services Benefit may not be used to pay for any charges for services described in the Charges Not Covered or Exceptions provisions of the Policy. In addition, the Alternate Services Benefit may not be used to supplement existing coverage limits under this Policy.

You may choose to discontinue the use of Alternate Services Benefits at any time.

Payment of the Alternate Services Benefit does not waive any of Your or Our rights under the Policy.

2. The provision captioned "Time of Payment of Claims" found in the CLAIMS section of Your Policy is deleted in its entirety and replaced with the following provision.

#### **Time of Payment of Claims**

Benefits under this Policy are payable after services have been rendered and charges have been incurred for such services.

We will send claim payment no later than 30 days after We receive notice of claim and Proof of Loss, provided that all Policy requirements have been satisfied. If We take more than 30 days to send the claim payment, We will pay interest on the amount of the claim that should have been paid, beginning 31 days after receiving all required information, until payment is made. Interest will be at the rate of 1% per month (or a higher rate if required by state law or regulation).

3. The following provision is inserted into the CLAIMS section of Your Policy following immediately after the provision captioned "Appeals".

#### **Independent Third Party Review**

You have the right to request an Independent Third Party Review if the Claim Appeals Review Board upholds a denial of Your claim based upon a determination that You do not need:

- Substantial Assistance to perform at least two Activities of Daily Living; or
- Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

We will provide You with written instructions on Your right to request an Independent Third Party Review when we notify you of the Claim Appeals Review Board's decision. You must make a request for an Independent Third Party Review in writing no later than 60-days after the date of Our notice informing You of the Claim Appeals Review Board's decision. The role of the Independent Third Party is to review relevant material related to the denial of Your claim that We provide. You will not undergo an exam. The Independent Third Party will provide both You and Us with written notice of its final decision. The decision of the Independent Third Party is final and binding on Us.

We will pay the costs associated with an Independent Third Party Review.

The Independent Third Party must be either:

- mutually agreed to by You and Us; or
- state approved or certified to conduct such reviews if the state requires such approvals or certifications.

In addition, an Independent Third Party must:

- be, or have on staff or contract with a qualified and licensed health care professional in an appropriate field for determining an individual's ability to perform the Activities of Daily Living or an individual's Cognitive Impairment, whichever applies to Your claim;
- not be affiliated with nor in any manner related to an entity or individual that previously provided care or services to You;
- not employ a licensed health care professional who is associated with Us or related to You in any manner; and
- not be compensated in any manner that is dependent upon the outcome of the review.

4. The following provision is added to the end of the GENERAL PROVISIONS section of Your Policy.

### **Changes in Your Coverage**

Please contact Us if You would like to make any changes in Your coverage.

On each Policy anniversary, You have the right to request an increase to Your Long Term Care Benefit Amount in \$10 increments if You elected the daily option, or \$100 increments if You elected the monthly option. Your Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will increase by the same percentage. You must make the request in writing, and You must meet the approval of Our underwriting department. If We approve Your request, You must pay an additional premium for the increase in coverage. The premium for the additional coverage will be based upon Your attained age and rating class on the date You make this request, at the rates then in effect. The premium for Your existing coverage will not change as a result of Your requested increase.

At any time, You may request a decrease to Your Long Term Care Benefit Amount in \$10 increments if You elected the daily option, or \$100 increments if You elected the monthly option. The decrease will take effect on Your next premium due date. Your Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will decrease by the same percentage. You must make the request in writing, and any election to decrease coverage is not subject to approval of Our underwriting department. The premium reduction for any decreased coverage will be based on your age at the time the coverage to be reduced was issued.

The amount of a benefit increase or decrease is subject to available Policy options at the time of Your request. At the time You make a request to change Your coverage, We will also provide You with information on any additional increase or decreases options that are currently available to You.

### **Termination**

This Endorsement will terminate when the Policy terminates.

Signed for the Company at Boston, Massachusetts:



Secretary



## JOHN HANCOCK LIFE INSURANCE COMPANY

### ENDORSEMENT

#### CPI COMPOUND INFLATION COVERAGE AND GUARANTEED INCREASE OPTION

**This Endorsement explains how Your Long Term Care Benefit Amount increases to provide protection against the increasing cost of long term care due to inflation.**

This Endorsement is part of, and attached to Your Policy. It is subject to all the provisions of the Policy unless otherwise provided below.

#### **Annual CPI Compound Increase in Long Term Care Benefit Amount**

We will increase the current Long Term Care Benefit Amount on each Policy anniversary, while this Policy is in effect, beginning with the first Policy anniversary. The Long Term Care Benefit Amount will be increased by the percentage change in the CPI three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long Term Care Benefit Amount. When the Long Term Care Benefit Amount is increased, the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long Term Care Benefit Amount and rounded to the nearest dollar.

CPI means the non-seasonally adjusted Consumer Price Index, Urban, All Items, published by the Bureau of Labor Statistics of the United States Department of Labor (CPI). If the CPI is discontinued, if there is a delay in the announcement of the CPI, or if its method of computation is changed, We may use another nationally published index. "CPI" will then mean the chosen index.

No inflation adjustment will be made while this Policy is in effect under the provisions of any nonforfeiture benefit.

**The premium for this inflation coverage is included in Your Policy premium. Your premium will not change for any annual automatic CPI Compound increase, except as described in the Policy.**

#### **Guaranteed Increase Option**

**Important Notice – The Guaranteed Increase Option is *not* applicable to You if You are paying Your premium via the Ten-Year Premium Payment Option or the Paid-Up at Age 65 Payment Option or if You purchased the Survivorship and Waiver of Premium Benefit or Family Care Benefit.**

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the Long Term Care Benefit Amount that was in effect immediately prior to that Option Date. This increase is in addition to the annual automatic CPI Compound increase described above. No additional underwriting will be required.

At the time of each offer, We will provide You with information regarding: Your current Long Term Care Benefit Amount; any increased benefit amount attributable to the CPI Compound increase due to take effect on that Option Date); the amount of increase available to You under this Guaranteed Increase Option; the additional premium amount for the increase under this Guaranteed Increase Option; and instructions on how You may elect this increase. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

If You elect an increase under the Guaranteed Increase Option, the amount of the annual automatic CPI Compound increase on that Option Date will be based on Your Long Term Care Benefit Amount prior to this additional purchase.

**If You do not elect an increase when offered, that increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers.**

The premium for any increase under the Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect.

When the Long Term Care Benefit Amount is increased under the Guaranteed Increase Option, the remaining Policy Limit (as well as any remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long Term Care Benefit Amount and rounded to the nearest dollar.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- any benefits have been payable under Your Policy during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 91st birthday.

No Guaranteed Increase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

### **Termination**

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted. This Endorsement will terminate when the Policy terminates, or when the Policy is continued under the provisions of any nonforfeiture benefit.

Signed for the Company at Boston, Massachusetts:



Secretary

# 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 Enhanced Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)

Monthly Benefit Amount: \$ \_\_\_\_\_ \$1,500 - \$15,000 in \$100 increments (Limit of \$7,500 for ages 80-84)

Daily Benefit Amount: \$ \_\_\_\_\_ \$50 - \$500 in \$10 increments (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  365

2d. Inflation Protection Options:

CPI Compound Inflation

5% Compound Inflation

5% Simple Inflation

None/Guaranteed Purchase Option (GPO) – this is the default if you do not select an inflation option above. This choice includes a Guaranteed Purchase Option unless you select Survivorship/Waiver of Premium, FamilyCare or a Limited Payment Option.  
*(Please read. You **must** check the box below if you elected the None/GPO option.)*

2e. Rejection of Inflation Protection:

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 CPI Compound, 5% Compound and 5% Simple Inflation options and I reject inflation protection.

2f. Optional Benefits:

**Partner & Family Benefits**

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

Survivorship/Waiver of Premium

FamilyCare\* Designate the additional family member(s) to be covered and in the order you wish them to succeed you as policyholder in the event of death or lapse. Each family member must complete the FamilyCare Supplemental Addendum and will be subject to Underwriting approval. Submit each Addendum with this Application.

1 \_\_\_\_\_

2 \_\_\_\_\_ 3 \_\_\_\_\_

**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. Please elect a beneficiary for the return of any unearned premium and if you are age 64 or younger for the Return of Premium upon Death, or you elected the optional Enhanced Return of Premium Upon Death. 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 or an immediate family member of the same generation, with whom you have been living together for at least the past 3 years? .....  Yes  No

3d. Is your Spouse, Partner or immediate family member of the same generation 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): \_\_\_\_\_

### Family Discount *(Not available with the Sponsored Group Discount)*

3e. Are you applying for a family discount? If YES, please list two other family members applying for, or who currently have a John Hancock individual long-term care insurance policy and their relationship to you.....  Yes  No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Policy # (if available): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### Valued Client Discount *(Not available with the Sponsored Group Discount)*

3f. Do you currently own a Life Insurance Policy or Annuity Contract with John Hancock of Manulife?  Yes  No

### Sponsored Group Discount *(Not available with the Family Discount or Valued Client Discount)*

3g. Do you belong to a sponsored group?  Yes  No

If YES, Sponsored Group #: \_\_\_\_\_ and Sponsored Group Name: \_\_\_\_\_  
*(Please also provide proof of employment/membership with sponsored group.)]*

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

Please check YES or NO beside each question.

4a. Do you currently have, or have you ever had a diagnosis for:

Alzheimer's Disease	Huntington's Chorea	Multiple Sclerosis	Schizophrenia
Amyotrophic Lateral Sclerosis	Memory Loss	Muscular Dystrophy	Scleroderma
Cystic Fibrosis	Mental Retardation	Myasthenia Gravis	Spinal Cord Injury
Dementia	Multiple Myeloma	Parkinson's Disease	Stroke/CVA.....

Yes  No

4b. Do you require mechanical or 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, crutches, 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. 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.

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Reason Prescribed</i>	<i>Physician Name</i>

[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: \_\_\_\_\_  
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 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 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, medical or health insurance coverage with the policy for which you are applying? If YES, please provide details below .....  Yes  No

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

**Fraud Notice.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

## [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 modal 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 Potential Rate Increase Disclosure Form, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacement is involved). If eligible for Medicare, I have received the "Guide to Health Insurance for People with Medicare".

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

[I 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:**

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:

**APPLICATION for Individual Long-Term Care Insurance**  
[through XXXXX XXXX]

**John Hancock Life Insurance Company**



*Please Note: If you make any changes to the application, you must initial those changes. You cannot make changes to dates or signatures.*

**PART 1 – PERSONAL INFORMATION**

[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: \_\_\_\_\_ ]

**PART 2 – SHOULD YOU PROCEED WITH THIS APPLICATION?**

Please check YES or NO beside each question. If YES, circle all diagnoses or conditions that are applicable.

- 2a. Do you currently have, or have you ever had a diagnosis for:  
 • Alzheimer's • Amyotrophic Lateral Sclerosis • Cerebral Atrophy • Cirrhosis • Cystic Fibrosis • Crest • Dementia • Diabetes with greater than 49 units of insulin • Kidney Failure • Memory Loss • Mental Retardation • Metastatic Cancer • Mixed Connective Tissue Disease • Multiple Sclerosis • Muscular Dystrophy • Neurological conditions affecting the brain or spinal cord • Huntington's Chorea • Multiple Myeloma • Organic Brain Syndrome • Parkinson's • Post Polio Paralytic Syndrome • Schizophrenia • Scleroderma • Spinal Cord Injury • Myasthenia Gravis • Stroke/CVA • TIAs (2 or more)? .....  Yes  No
- 2b. Do you require mechanical or human assistance or supervision in any of the following activities:  
 • eating • dressing • toileting • transferring from bed to chair • walking • maintaining continence • bathing? .....  Yes  No
- 2c. 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
- 2d. Do you currently use one of the following medical devices:  
 • wheelchair • walker • hospital bed • quad cane • crutches • oxygen • stairlift • dialysis? .....  Yes  No
- 2e. 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
- 2f. Are you currently receiving Social Security disability benefits? .....  Yes  No

**STOP!** If you answered YES to any questions 2a through 2f above, please contact [XXXX at XXX-XXX-XXXX]. If you answered NO to every question, please continue.

**[PART 3 – CUSTOM CARE II ENHANCED SELECTION OF BENEFITS**

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

3a. Custom Care II Enhanced Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)

- Monthly Benefit Amount: \$ \_\_\_\_\_ \$1,500 - \$15,000 in \$100 increments (Limit of \$7,500 for ages 80-84)
- Daily Benefit Amount: \$ \_\_\_\_\_ \$50 - \$500 in \$10 increments (Limit of \$250 for ages 80-84)

3b. 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.)*

3c. Elimination Period (Dates of Service):  30\*  60\*  90  180  365

3d. Inflation Protection Options:

- CPI Compound Inflation
- 5% Compound Inflation
- 5% Simple Inflation
- None/Guaranteed Purchase Option (GPO)** – this is the default if you do not select an inflation option above. This choice includes the Guaranteed Purchase Option unless you select Survivorship/Waiver of Premium, FamilyCare or a Limited Payment Option.  
*(Please read. You **must** check the box below if you elected the None/GPO option.)*

3e. Rejection of Inflation Protection:

- 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 CPI Compound, 5% Compound and 5% Simple Inflation options and I reject inflation protection.

3f. Optional Benefits:

- Survivorship/Waiver of Premium
- Waiver of the Home Care Elimination Period\*
- Shared Care\* *Please designate your spouse/partner to be covered by this rider:* \_\_\_\_\_
- FamilyCare\* *Please designate the additional family member(s) you wish to be covered by this rider and in the order you wish them to succeed you as policyholder in the event of your death or lapse of the policy. Each family member will be required to complete the FamilyCare Supplemental Addendum; and be subject to Underwriting approval. Please make sure each Supplemental Addendum is submitted with this Application.*  
 (1) \_\_\_\_\_ (3) \_\_\_\_\_  
 (2) \_\_\_\_\_ (4) \_\_\_\_\_
- Enhanced Return of Premium Upon Death\* *Please refer to question 4e to select a beneficiary if you elected this benefit.*
- Nonforfeiture

3g. 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 4 – DISCOUNTS, FAMILY & OTHER NEEDED INFORMATION**

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

**Marital/Partner Discount**

- 4a. Are you married?.....  Yes  No
- 4b. 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 5 years? .....  Yes  No
- 4c. Have you lived together with a sibling of the same generation for at least the past 5 years?.....  Yes  No
- 4d. Is your Spouse, Partner or sibling 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): \_\_\_\_\_ ]

**[Part 4 - Continued**

4e. **Beneficiary Designation:** Please elect a beneficiary for the return of any unearned premium and if you are age 64 or younger for the Return of Premium Upon Death, or you elected the optional Enhanced Return of Premium Upon Death. 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 and Address: \_\_\_\_\_

**PART 5 – INSURANCE HISTORY**

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

5a. Are you covered by Medicaid? If YES, list reason:.....  Yes  No

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

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

5c. Have you had another long-term care insurance policy or certificate in force during the last 12 months? If YES, please provide details below .....  Yes  No

5d. Do you have another long-term care insurance policy or certificate in force (including a health care service, Health maintenance organization or Medicare Supplement contract)? If YES, please provide details below. ....  Yes  No

5e. Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying? If YES, please provide details below.....  Yes  No

Company	Policy/Cert#	Annual Premium	Benefit Type & Amounts	Currently In Force?	Is it being replaced?

**PART 6 – PAYMENT & ADMINISTRATION**

6a. **Advance Payment:**

I have enclosed my advance payment in the amount of \$ \_\_\_\_\_  
*(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 modal premium. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.)*

6b. **Payment Type:** You must choose one of the following options:

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

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

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) \_\_\_\_\_

Signature(s): \_\_\_\_\_

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

3.  **Credit Card:** I authorize John Hancock to charge all future premium payments to the credit card listed below until I provide John Hancock with written instructions otherwise.

Payment Frequency:  Quarterly  Monthly

Card Type:  Mastercard  Visa

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

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

Cardholder's Signature: \_\_\_\_\_

**[PART 6 – CONTINUED**

**6c. 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.*

**6d. Special Requests:** \_\_\_\_\_

**PART 7 – MEDICAL HISTORY & LIFESTYLE**

**7a.** Have you been seen by your primary care physician within the past 18 months? If yes, date seen: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Who is your primary care physician? (Please list name, address and telephone number.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check YES or NO beside each question. If YES, circle all diagnoses or conditions that are applicable.

**7b.** Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?  Yes  No

**7c.** 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. **Circulatory Disorders:** • Transient Ischemic Attack • Amaurosis Fugax • Heart Arrhythmias  
 • Valvular Disease • Cardiomyopathy • Congestive Heart Failure • Aneurysm • Coronary Artery Disease  
 • High Blood Pressure • Peripheral Vascular Disease • Carotid Artery Disease • Embolisms.....  Yes  No
- 2. **Endocrine and Pituitary Disorders:** • Diabetes • Addison's • Pancreatitis • Cushing's .....  Yes  No
- 3. **Cancers:** • Leukemia • Lymphoma • Tumors • Melanoma • Squamous Cell • Sarcomas.....  Yes  No
- 4. **Genitourinary Disorders:**• Renal Insufficiency • Incontinence • Prostrate Disorders • Bladder Disorders .  Yes  No
- 5. **Gastrointestinal Disorders:** • Hepatitis • Ulcerative Colitis • Crohn's Disease • Liver Disorders.....  Yes  No
- 6. **Neurological Disorders:** • Mental Illness • Depression • Seizures • Tremors • Neuropathy • Syncope  
 • Anxiety • Chronic Fatigue Syndrome.....  Yes  No
- 7. **Blood Disorders:** •Anemia • Polycythemia Vera • Thrombocytopenia • Hemochromatosis .....  Yes  No
- 8. **Musculoskeletal Disorders:** • Osteoporosis • Arthritis • Rheumatoid Arthritis • Osteoarthritis • Fractures • Fibromyalgia  
 • Degenerative Joint Disease • Scoliosis • Spinal Stenosis • Lupus • Polymyalgia Rheumatica • Osteopenia.....  Yes  No
- 9. **Respiratory Disorders:** • Emphysema • Bronchitis • Asthma • Bronchiectasis • Asbestosis  
 • Sarcoidosis • Chronic Obstructive Pulmonary Disease.....  Yes  No
- 10. **Eye & Ear Disorders:** • Macular Degeneration • Glaucoma • Retinitis Pigmentosa • Labrynthitis • Meniere's/Vertigo .....  Yes  No
- 11. **Substance Abuse:** • Alcoholism • Drug dependency • Illicit drug use .....  Yes  No

**7d.** 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

**7e.** Within the last 5 years has any surgery or test(s) been recommended that have not been performed?.....  Yes  No

**7f.** Do you require human assistance or supervision in any of the following activities?  
 • Meal preparation • House cleaning • Shopping • Laundry • Transportation • Taking medications.....  Yes  No

**7g.** 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

**7h.** You may be contacted by a nurse on John Hancock's behalf to review your medical history and information. This interview is not an examination. We merely ask you detailed medical questions to help us underwrite your application.

Best Time to Call (3-hour intervals starting at): \_\_\_\_\_ Weekend Calls:  Yes  No  
 Day Telephone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Evening Telephone: ( ) \_\_\_\_\_  
 Cell Telephone: ( ) \_\_\_\_\_ Your E-Mail Address: (optional) \_\_\_\_\_

If you answered YES to any of questions 7c through 7h above, please provide the full details in section 7i on page 5.]

**PART 7 -- CONTINUED**

7i. **MEDICAL HISTORY DETAILS** – If you answered YES to any of questions 7c through 7h on the prior page, provide full detail here.

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

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

<i>Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Reason Prescribed</i>	<i>Physician Name</i>

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

7k. Are you currently employed? If so, what is your occupation:

7l. 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 .....  Yes  No

7m. 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? .....  Yes  No

If you answered YES to questions 7l or 7m above, provide full details below.

<i>Ques.#</i>	<i>Details</i>

**Fraud Notice.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

## PART 8 – PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. (You must check off one box below.)

- 8a.  I elect to designate the person below to receive such notice.
- 8b.  I elect NOT to designate any person to receive such notice.

Name (First, M.I., Last): \_\_\_\_\_  
Street 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 may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, or other questionnaire or test. I understand that no agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.

[For the purpose of underwriting my application, if I make 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 Potential Rate Increase Disclosure Form, 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 ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.**

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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**

**Interview:**

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

**Replacement:**

To the best of my knowledge, replacement of other insurance  is/  is not involved in this transaction. Listed below are all other health insurance policies I 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:**

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

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

Signature of Licensed Agent::

Agent Name (Please print):

Date:

 /  / 

**[CREDIT FOR APPLICATION**

Producer/Agent Name (Please print):

Agency/Bank/Firm Name:

Social Security #:

Tel. #

Annual Premium: \$

Fax#

JH Agency Code (if known):

Email:

Signator Career Only:

Payroll Number:

Contract Code:

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:



John Hancock Life Insurance Company

Prescreen No: \_\_\_\_\_

Control No: \_\_\_\_\_

## Application for Individual Long-Term Care Insurance

Applicant's Name: \_\_\_\_\_

[Agent Use Only. Please check one of the following boxes to indicate who this application is for:

Group Case Numbers:]

MGSJ Employee < age 65     MGSJ Employee < age 65 requesting Buy-Up

MGSJ #: \_\_\_\_\_ ]

MGTI Employee < age 65     MGTI Employee < age 65 requesting Buy-Up

MGTI #: \_\_\_\_\_ ]

### Part 1 – Custom Care II Enhanced Selection of Benefits

1a. Custom Care II Enhanced Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)

Monthly Benefit Amount: \$ \_\_\_\_\_ \$1,500 - \$15,000 in \$100 increments

Daily Benefit Amount: \$ \_\_\_\_\_ \$50 - \$500 in \$10 increments

1b. Benefit Periods (Years):     2     3     4     5     6     10

(The Benefit Period is used to determine the Policy Limit shown in the Policy Schedule.)

1c. Elimination Period (Dates of Service):     30     60     90     180     365

1d. Inflation Protection Options

CPI Compound

5% Compound

5% Simple

None/Guaranteed Purchase Option (GPO) - this is the default if you do not select an inflation option above. This choice includes a Guaranteed Purchase Option unless you select Survivorship/Waiver, FamilyCare or a Limited Payment Option.

(Please read. You **must** check the box below if you do **not** select an Inflation option.)

1e. Rejection of Inflation Protection:

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 CPI Compound 5% Compound and 5% Simple Inflation options, and I reject inflation protection.

1f. Optional Benefits:

SharedCare (Complete question 1h. Not available with Enhanced Return of Premium.)

Survivorship/Waiver of Premium (Not available with Limited Payment Options.)

Waiver of the Home Care Elimination Period (Not available with the 180 or 365-day Elimination Period.)

Additional Cash Benefit (See the Outline of Coverage for important Federal income tax information regarding this option.)

Restoration of Benefits (Not available with 2 or 10-year Benefit Period.)

Enhanced Return of Premium Upon Death (Please complete question 1i. Not available with SharedCare.)

Nonforfeiture

1g. 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.

**Optional and Other Benefit Information – Only complete the questions which are associated with the optional benefit you selected, if any.**

1h. SharedCare – Designate your spouse/partner to be covered by this rider. \_\_\_\_\_

1i. Beneficiary Designation - Please elect a beneficiary for the return of any unearned premium and if you are age 64 or younger for the Return of Premium Upon Death, or you elected the optional Enhanced Return of Premium Upon Death. 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). \_\_\_\_\_ ]

## Part 2: Personal and Business Information

### Personal Information:

2a.	Mr. / Mrs./Ms. (Circle One)	First Name:	M.I.:	Last Name:
2b.	Street Address:			
	City:	State:	Zip Code:	
2c.	SS #:	2d.	Birthdate (mm/dd/yyyy):     /     /	
2e.	Birth Place (State, Country)		2f. <input type="checkbox"/> Male <input type="checkbox"/> Female	
2g.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partner			

### Marital/Partner Discount: *You may be eligible for certain discounts. Please indicate "YES" or "NO" beside the question below.*

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	2h. If you are married, is your spouse also applying for this insurance or does he/she currently have a John Hancock individual long-term care insurance policy? If Yes, provide the following: First Name: _____ Last Name: _____ SS#: _____ or Policy#: _____
<input type="checkbox"/>	<input type="checkbox"/>	2i. If you are not married, are you in a committed relationship with a partner with whom you have been living for a period of at least 3 years and is your partner applying for this insurance or does he/she currently have a John Hancock individual long-term care insurance policy? If Yes, provide the following: First Name: _____ Last Name: _____ SS#: _____ or Policy#: _____

### Business Information: *Only employees need to complete questions 2j – 2l.*

2j.	Sponsoring Employer Name:		
2k.	Street Address of Employer:		
	City:	State:	Zip Code:
2l.	Are you currently actively at work with this sponsoring employer? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(You are considered to be "actively at work" if during the last 6 months you have worked for the sponsoring employer for a minimum of 30 hours per week and missed 10 or fewer days during that time period due to illness, injury or infirmity. An employee on leave of absence or receiving Social Security Disability Income is not considered actively at work).</i>		

## Part 3: Underwriting Questions

### Section A

- Please check "yes" or "no" to each question. If "yes", circle all diagnoses or conditions that apply.
- If you answer "yes" to any of questions 3a – 3d, then we suggest you do not submit an application. We will be unable to offer you coverage.

YES	NO																												
<input type="checkbox"/>	<input type="checkbox"/>	3a. Do you have or have you been advised by a member of the medical profession that you have any of the following: <table border="0" style="width: 100%;"> <tr> <td>• Alzheimer's Disease</td> <td>• Memory Loss</td> <td>• Paralysis</td> </tr> <tr> <td>• ALS (Lou Gehrig's Disease)</td> <td>• Multiple Sclerosis</td> <td>• Post Polio Paralytic Syndrome</td> </tr> <tr> <td>• Cirrhosis</td> <td>• Muscular Dystrophy</td> <td>• Schizophrenia</td> </tr> <tr> <td>• Chronic Kidney Failure</td> <td>• Neurological Conditions</td> <td>• Scleroderma</td> </tr> <tr> <td>• Dementia</td> <td>  affection the Brain or</td> <td>• Systemic Lupus Erythematosus</td> </tr> <tr> <td>• Diabetes - treated with greater than 49 units</td> <td>  Spinal Cord</td> <td>• Stroke/ CVA</td> </tr> <tr> <td>  of insulin or with amputation or ongoing</td> <td>• Organic Brain Syndrome</td> <td>• TIA's 2 or more</td> </tr> <tr> <td>  complications affecting the kidney</td> <td>• Parkinson's Disease</td> <td></td> </tr> <tr> <td>• Mental Retardation</td> <td></td> <td></td> </tr> </table>	• Alzheimer's Disease	• Memory Loss	• Paralysis	• ALS (Lou Gehrig's Disease)	• Multiple Sclerosis	• Post Polio Paralytic Syndrome	• Cirrhosis	• Muscular Dystrophy	• Schizophrenia	• Chronic Kidney Failure	• Neurological Conditions	• Scleroderma	• Dementia	affection the Brain or	• Systemic Lupus Erythematosus	• Diabetes - treated with greater than 49 units	Spinal Cord	• Stroke/ CVA	of insulin or with amputation or ongoing	• Organic Brain Syndrome	• TIA's 2 or more	complications affecting the kidney	• Parkinson's Disease		• Mental Retardation		
• Alzheimer's Disease	• Memory Loss	• Paralysis																											
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of insulin or with amputation or ongoing	• Organic Brain Syndrome	• TIA's 2 or more																											
complications affecting the kidney	• Parkinson's Disease																												
• Mental Retardation																													
<input type="checkbox"/>	<input type="checkbox"/>	3b. Are you receiving home health care or do you require mechanical or human assistance or supervision with any of the following activities: • bathing • dressing • eating • continence • toileting • walking • transferring to or from a bed or a chair?																											
<input type="checkbox"/>	<input type="checkbox"/>	3c. Do you currently use any of the following medical devices: • wheelchair • walker • quad cane • crutches • oxygen • motorized scooter • stair lift • dialysis?																											
<input type="checkbox"/>	<input type="checkbox"/>	3d. Have you been diagnosed or treated by a member of the medical profession for: AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?																											
<input type="checkbox"/>	<input type="checkbox"/>	3e. Are you currently receiving Social Security Disability, Worker's Compensation or Long Term Disability Benefits?																											

## Instructions for Completing Underwriting Questions:

- If you are an employee under age 65, applying for Modified Guarantee Standard Issue, skip to Part 4 on page 4.
- If you are under age 65 and an employee or spouse/partner applying for Modified Guarantee to Issue, now complete Section B.

<b>Section B</b>	<ul style="list-style-type: none"> <li>• Instructions: Please check "yes" or "no" to each question.</li> <li>• If you answer "YES" to questions 3e – 3j provide details in question 3o. If you have taken any prescription medication in the past 12 months, provide details in question 3p.</li> </ul>
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YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	3e. In the last 5 years have you been hospitalized, consulted with or been treated by a physician for any disease or condition not previously stated in questions 3a – 3d above?
<input type="checkbox"/>	<input type="checkbox"/>	3f. In the last 5 years has it been recommended that you have any surgery, tests or procedures which have not been performed?
<input type="checkbox"/>	<input type="checkbox"/>	3g. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?
<input type="checkbox"/>	<input type="checkbox"/>	3h. 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 attending adult day care?
<input type="checkbox"/>	<input type="checkbox"/>	3i. Have you ever had an application for life, disability or long-term care insurance declined, postponed, modified or rated?
<input type="checkbox"/>	<input type="checkbox"/>	3j. Do you <u>require</u> ( <i>excluding gender bias and convenience</i> ) human assistance or supervision in any of the following activities? • Meal preparation • Laundry • House cleaning • Shopping • Transportation • Taking medications?

3k. Height: \_\_\_\_\_ **→→→** 3l. Weight: \_\_\_\_\_

3m. Who is your primary care physician?  Check here if you do not have a Primary Care Physician

Name: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_

Have you seen your primary care physician within the past 18 months? If Yes, date and reason:

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

3n. A nurse may contact you by telephone on John Hancock's behalf. You will be asked detailed medical questions to help us evaluate your application.

Best Time to Call (3-hour intervals): \_\_\_\_\_ Weekend Calls:  YES  NO

Day Telephone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Evening Telephone: (\_\_\_\_) \_\_\_\_\_

Cell Telephone: (\_\_\_\_) \_\_\_\_\_ E-Mail Address (optional): \_\_\_\_\_

**3o. MEDICAL HISTORY DETAILS:** If you answered "YES" to 3e – 3j above, provide full details here.

Question Number	Diagnosis, Illness or Injury	Diagnosis Date	Treatment Dates	Include Physician/ Provider Name, Address and Phone Number and Explanation or Comments

**3p. MEDICATION DETAILS:** For individuals completing Parts B, list all prescription medications taken during the past 12 months.

Check here if you have not taking any medications

Medication Name	Dosage	Frequency	Reason Prescribed	Prescribing Physician Name

**Fraud Notice.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

Instructions: Parts 4 – 7 of this application should be completed by all applicants.

## Part 4 – Insurance History

YES NO Please check "YES" or "NO" beside each question or statement. If Yes, provide details in space provided below.

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 4a. Are you covered under Medicaid ( <i>not Medicare</i> )? If YES, details:  |
| <input type="checkbox"/> | <input type="checkbox"/> | 4b. Do you have another long-term care insurance policy or certificate in force (including a health care service, health maintenance organization or Medicare Supplement contract)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4c. Did you have another long-term care insurance policy or certificate in force during the last 12 months?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4d. Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying?   |

Company	Policy/Cert.#	Annual Premium	Benefit Type & Amounts	Currently In Force?	Is it being Replaced?

## Part 5 – Payment Information

5a. Who will be paying the premium?  100% Employer Paid  Partial Employer Paid  Insured Paid

5b. Payment Types: You may choose one of the following options.

1.  Direct Bill →→ Select a Payment Frequency:  Annual  Semi-Annual  Quarterly

2.  Monthly Bank Draft: Complete the following information and attach a voided copy of your advance payment check.

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

Bank Name: \_\_\_\_\_ Bank Routing #: \_\_\_\_\_

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

Name(s) of Depositor(s): \_\_\_\_\_

Signature(s): \_\_\_\_\_

*Note: The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on the selected draft day requested above.*

3.  List Billing List Bill Group #: \_\_\_\_\_

5c. Limited Pay Options: If you choose any Limited-Pay Option, then the Guaranteed Purchase Option will not be available to you.

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

## Part 6 – 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.*)

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

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone#: \_\_\_\_\_

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

## Part 7 – Agreement & Acknowledgement

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 may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, or other questionnaire or test. I understand that no agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application. I understand that John Hancock may disapprove this application if all application, underwriting and sponsored group program requirements are not met within [90-days] of the date I sign this application. In such instance, John Hancock will notify me that my application has been disapproved.

I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid prior to the policy's effective date. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.) I understand that in order to keep my policy in force, I must pay all the required premiums when due.

Acknowledgments: I have received the policy Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure Form, 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 ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.**

---

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

Signed at: \_\_\_\_\_  
City State Signature of Applicant Date

## [Part 8 – Producer/Agent’s Statement

**Interview:**

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

The Applicant was not interviewed by me in person or by telephone on this date.

**Replacement:**

To the best of my knowledge, replacement of other insurance  is /  is not involved in this transaction. Listed below are all other health insurance policies I 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:** I have reviewed the Underwriting Guidelines and the information provided in this Application.

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

Signature of Licensed Agent: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_ State Where Signed: \_\_\_\_\_ ]

## [Credit for Application

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

JH Producer Payroll Number (Agent #): \_\_\_\_\_

Contract Code (JHFN Career Only): \_\_\_\_\_

Producer’s Social Security # or Tax ID #: \_\_\_\_\_

Market Code: \_\_\_\_\_

Level Code: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

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

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

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

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

**If more than one Agent was involved in the sale of this application, provide details below:**

Agent Name:	JH Producer Payroll #:	SS# or Tax ID#:	Percentage:
			]



John Hancock Life Insurance Company

Prescreen No: \_\_\_\_\_

Control No: \_\_\_\_\_

# Application for Individual Long-Term Care Insurance

Applicant's Name: \_\_\_\_\_

[Agent Use Only. Please check one of the following boxes to indicate who this application is for:

<input type="checkbox"/> MGSi Employee < age 65	<input type="checkbox"/> MGSi Employee < age 65 requesting Buy-Up	Group Case Numbers:
<input type="checkbox"/> MGTI Employee < age 65	<input type="checkbox"/> MGTI Employee < age 65 requesting Buy-Up	
<input type="checkbox"/> Spouse/Partner < age 65		<input type="checkbox"/> MGTI #: _____
<input type="checkbox"/> Other Individual (Employees/Spouse/Partner age 65 and over, Retirees, Family members)		<input type="checkbox"/> Spon Group#: _____ ]

## Part 1 – Custom Care II Enhanced Selection of Benefits

\* Not available for ages 80 – 84.

1a. Custom Care II Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)

Monthly Benefit Amount: \$ \_\_\_\_\_ \$1,500 - \$15,000 in \$100 increments (Limit of \$7,500 for ages 80-84)

Daily Benefit Amount: \$ \_\_\_\_\_ \$50 - \$500 in \$10 increments (Limit of \$250 for ages 80-84)

1b. Benefit Periods (Years):  2  3  4\*  5\*  6\*  10\*  Lifetime\*  
(The Benefit Period is used to determine the Policy Limit shown in the Policy Schedule.)

1c. Elimination Period (Dates of Service):  30\*  60\*  90  180  365

1d. Inflation Protection Options

CPI Compound

5% Compound

5% Simple

None/Guaranteed Purchase Option (GPO) - this is the default if you do not select an inflation option above. This choice includes a Guaranteed Purchase Option unless you select Survivorship/Waiver, FamilyCare or a Limited Payment Option.  
(Please read. You **must** check the box below if you elected the None/GPO Option.)

1e. Rejection of Inflation Protection:

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.

1f. Optional Benefits:

SharedCare\* (Complete question 1h. Not available with Lifetime Benefit Period or Enhanced Return of Premium.)

Survivorship/Waiver of Premium (Not available with Limited Payment Option.)

Waiver of the Home Care Elimination Period\* (Not available with the 180 or 365-day Elimination Period.)

Additional Cash Benefit (See the Outline of Coverage for important Federal income tax information regarding this option.)

Restoration of Benefits\* (Not available with 2, 10-year or Lifetime Benefit Period.)

Enhanced Return of Premium Upon Death\* (Please complete question 1i. Not available with SharedCare.)

Nonforfeiture

1g. 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.

### Optional and Other Benefit Information – Only complete the questions which are associated with the optional benefit you selected, if any.

1h. SharedCare – Designate your spouse/partner to be covered by this rider. \_\_\_\_\_

1i. Beneficiary Designation - Please elect a beneficiary for the return of any unearned premium and if you are age 64 or younger for the Return of Premium Upon Death, or you elected the optional Enhanced Return of Premium Upon Death. 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). \_\_\_\_\_ ]

## Part 2: Personal and Business Information

### Personal Information:

2a.	Mr. / Mrs./Ms. (Circle One)	First Name:	M.I.:	Last Name:
2b.	Street Address:			
	City:	State:	Zip Code:	
2c.	SS #:	2d.	Birthdate (mm/dd/yyyy):     /     /	
2e.	Birth Place (State, Country)		2f. <input type="checkbox"/> Male <input type="checkbox"/> Female	
2g.	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Partner			

### Marital/Partner Discount: *You may be eligible for certain discounts. Please indicate "YES" or "NO" beside the question below.*

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	2h. If you are married, is your spouse also applying for this insurance or does he/she currently have a John Hancock individual long-term care insurance policy? If Yes, provide the following: First Name: _____ Last Name: _____ SS#: _____ or Policy#: _____
<input type="checkbox"/>	<input type="checkbox"/>	2i. If you are not married, are you in a committed relationship with a partner with whom you have been living for a period of at least 3 years and is your partner applying for this insurance or does he/she currently have a John Hancock individual long-term care insurance policy? If Yes, provide the following: First Name: _____ Last Name: _____ SS#: _____ or Policy#: _____

### Business Information: *Only employees need to complete questions 2j – 2l.*

2j.	Sponsoring Employer Name:		
2k.	Street Address of Employer:		
	City:	State:	Zip Code:
2l.	Are you currently actively at work with this sponsoring employer? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(You are considered to be "actively at work" if during the last 6 months you have worked for the sponsoring employer for a minimum of 30 hours per week and missed 10 or fewer days during that time period due to illness, injury or infirmity. An employee on leave of absence or receiving Social Security Disability Income is not considered actively at work).</i>		

## Part 3: Underwriting Questions

### Section A

- Please check "yes" or "no" to each question. If "yes", circle all diagnoses or conditions that apply.
- If you answer "yes" to any of questions 3a – 3d, then we suggest you do not submit an application. We will be unable to offer you coverage.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	3a. Do you have or have you been advised by a member of the medical profession that you have any of the following: <ul style="list-style-type: none"> <li>• Alzheimer's Disease</li> <li>• ALS (Lou Gehrig's Disease)</li> <li>• Cirrhosis</li> <li>• Chronic Kidney Failure</li> <li>• Dementia</li> <li>• Diabetes treated with greater than 49 units of insulin</li> <li>• Mental Retardation</li> <li>• Memory Loss</li> <li>• Multiple Sclerosis</li> <li>• Muscular Dystrophy</li> <li>• Neurological Conditions affecting the Brain or Spinal Cord</li> <li>• Organic Brain Syndrome</li> <li>• Parkinson's Disease</li> <li>• Paralysis</li> <li>• Post Polio Paralytic Syndrome</li> <li>• Schizophrenia</li> <li>• Scleroderma</li> <li>• Systemic Lupus Erythematosus</li> <li>• Stroke/ CVA</li> <li>• TIA's 2 or more</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3b. Are you receiving home health care or do you require mechanical, human assistance or supervision with any of the following activities: <ul style="list-style-type: none"> <li>• bathing • dressing • eating • continence • toileting • walking • transferring to or from a bed or a chair?</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3c. Do you currently use any of the following medical devices: <ul style="list-style-type: none"> <li>• wheelchair • walker • quad cane • crutches • oxygen • motorized scooter • stair lift • dialysis?</li> </ul>
<input type="checkbox"/>	<input type="checkbox"/>	3d. Have you been diagnosed or treated by a member of the medical profession for: AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?

## Instructions for Completing Underwriting Questions:

- If you are an employee under age 65, applying for Modified Guarantee Standard Issue, skip to Part 4 on page 4.
- If you are under age 65 and an employee or spouse/partner applying for Modified Guarantee to Issue, now complete Section B of Part 3. You may also need to complete questions 3p and 3q based upon your answers in Section B.
- If neither of the above two situations apply to you, complete Sections B & C of Part 3.

<b>Section B</b>	<ul style="list-style-type: none"> <li>• Instructions: Please check "yes" or "no" to each question.</li> <li>• If you answer "YES" to questions 3e – 3i provide details in question 3p. If you have taken any prescription medication in the past 12 months, provide details in question 3q Medications.</li> </ul>
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YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	3e. In the last 5 years have you been hospitalized, consulted with or been treated by a physician for any disease or condition not previously stated in questions 3a – 3d above?
<input type="checkbox"/>	<input type="checkbox"/>	3f. In the last 5 years has it been recommended that you have any surgery, tests or procedures which have not been performed?
<input type="checkbox"/>	<input type="checkbox"/>	3g. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?
<input type="checkbox"/>	<input type="checkbox"/>	3h. 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 attending adult day care?
<input type="checkbox"/>	<input type="checkbox"/>	3i. Have you ever had an application for life, disability or long-term care insurance declined, postponed, modified or rated?

3j. Height: \_\_\_\_\_ **→→→** 3k. Weight: \_\_\_\_\_

3l. Who is your primary care physician?  Check here if you do not have a Primary Care Physician

Name: \_\_\_\_\_

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

Phone: (\_\_\_\_) \_\_\_\_\_

Have you seen your primary care physician within the past 18 months? If Yes, date and reason:

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

3m. A nurse may contact you by telephone on John Hancock's behalf. You will be asked detailed medical questions to help us evaluate your application.

Best Time to Call (3-hour intervals): \_\_\_\_\_ Weekend Calls:  YES  NO

Day Telephone: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_ Evening Telephone: (\_\_\_\_) \_\_\_\_\_

Cell Telephone: (\_\_\_\_) \_\_\_\_\_ E-Mail Address (optional): \_\_\_\_\_

<b>Section C</b>	<ul style="list-style-type: none"> <li>• Please check "YES" or "NO" beside each question.</li> <li>• If "YES", circle all diagnoses or conditions that are applicable and provide full details in question 3p. If you have taken any prescription medication in the past 12 months, provide details in question 3q Medications.</li> </ul>
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YES	NO	
		3n. 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?
<input type="checkbox"/>	<input type="checkbox"/>	1. Substance Abuse: • Alcoholism • Drug abuse
<input type="checkbox"/>	<input type="checkbox"/>	2. Blood Disorders: • Anemia • Polycythemia • Thrombocytopenia • Thrombocythemia • Hemochromatosis
<input type="checkbox"/>	<input type="checkbox"/>	3. Musculoskeletal Disorders: • Rheumatoid Arthritis • Osteoarthritis • Degenerative Joint Disease • Fractures • Spinal Stenosis • Joint Replacement Surgery • Osteoporosis • Osteopenia • Scoliosis • Degenerative Disc • Ankylosing Spondylitis • Fibromyalgia • Polymyalgia Rheumatica • Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	4. Cancers: • Cancer • Melanoma • Tumor • Hodgkin's Disease • Lymphoma • Leukemia • Bone Marrow disorder
<input type="checkbox"/>	<input type="checkbox"/>	5. Neurological Disorders: • Depression • Anxiety • Psychiatric disorder • Epilepsy • Seizures • Dizziness • Falls • Imbalance • Paralysis • Tremor • Neuropathy • Chronic Fatigue Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	6. Endocrine & Pituitary Disorders: • Addison's Disease • Diabetes • Disorder of Glucose Metabolism • Cushing's
<input type="checkbox"/>	<input type="checkbox"/>	7. Eye & Ear Disorders: • Glaucoma • Cataract • Macular Degeneration • Vision Impairment • Hearing Loss • Meniere's Disease or Labyrinthitis

<input type="checkbox"/>	<input type="checkbox"/>	8. Circulatory Disorders: • Coronary Artery Disease • High Blood Pressure • Heart Arrhythmia • Cardiomyopathy • Congestive Heart Failure • Transient Ischemic Attack (TIA) • Carotid Artery Disease • Aneurysm • Embolism • Peripheral Vascular Disease
<input type="checkbox"/>	<input type="checkbox"/>	9. Genitourinary Disorders: • Renal Insufficiency or Failure • Disorder of the Kidney • Incontinence • Prostate Disorders • Bladder Disorders
<input type="checkbox"/>	<input type="checkbox"/>	10. Respiratory Disorders: • Emphysema • Asthma • Chronic Obstructive Pulmonary Disease • Bronchitis • Tuberculosis (TB) • Chronic Lung Disease • Bronchietasis.
<input type="checkbox"/>	<input type="checkbox"/>	11. Gastrointestinal Disorders: • Hepatitis • Ulcerative Colitis • Crohn's Disease • Liver Disorders • Ulcer • Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	3o. Do you <u>require</u> ( <i>excluding gender bias and convenience</i> ) human assistance or supervision in any of the following activities? • Meal preparation • Laundry • House cleaning • Shopping • Transportation • Taking medications?

3p. MEDICAL HISTORY DETAILS: If you answered "YES" to 3e – 3i, 3n-3o above, provide full details here.

Question Number	Diagnosis, Illness or Injury	Diagnosis Date	Treatment Dates	Include Physician/ Provider Name, Address and Phone Number and Explanation or Comments

3q. MEDICATION DETAILS: For individuals completing Parts B & C above, list all prescription medications taken during the past 12 months.  Check here if you have not taking any medications

Medication Name	Dosage	Frequency	Reason Prescribed	Prescribing Physician Name

**Instructions: Parts 4 – 7 of this application should be completed by all applicants.**

## Part 4 – Insurance History

YES	NO	Please check "YES" or "NO" beside each question or statement. If Yes, provide details in space provided below.			
<input type="checkbox"/>	<input type="checkbox"/>	4a. Are you covered under Medicaid ( <i>not Medicare</i> )? If YES, details:			
<input type="checkbox"/>	<input type="checkbox"/>	4b. Do you have another long-term care insurance policy or certificate in force (including a health care service, health maintenance organization or Medicare Supplement contract)?			
<input type="checkbox"/>	<input type="checkbox"/>	4c. Did you have another long-term care insurance policy or certificate in force during the last 12 months?			
<input type="checkbox"/>	<input type="checkbox"/>	4d. Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying?			
Company	Policy/Cert.#	Annual Premium	Benefit Type & Amounts	Currently In Force?	Is it being Replaced?

## Part 5 – Payment Information

5a. Who will be paying the premium?  100% Employer Paid  Partial Employer Paid  Insured Paid

5b. Payment Types: You may choose one of the following options.

1.  Direct Bill →→ Select a Payment Frequency:  Annual  Semi-Annual  Quarterly

2.  Monthly Bank Draft: Complete the following information and attach a voided copy of your advance payment check.

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

Bank Name: \_\_\_\_\_ Bank Routing #: \_\_\_\_\_

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

Name(s) of Depositor(s): \_\_\_\_\_

Signature(s): \_\_\_\_\_

*Note: The first draft will occur on the premium-due date after the policy has been issued. Subsequent drafts will occur on the selected draft day requested above.*

3.  List Billing List Bill Group #: \_\_\_\_\_

5c. Limited Pay Options: *If you choose any Limited-Pay Option, then the Guaranteed Purchase Option will not be available to you.*

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

## Part 6 – 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.)*

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

First Name: \_\_\_\_\_

M.I. \_\_\_\_\_

Last Name: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

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

**Fraud Notice.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

## Part 7 – Agreement & Acknowledgement

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 may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, or other questionnaire or test. I understand that no agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application. I understand that John Hancock may disapprove this application if all application, underwriting and sponsored group program requirements are not met within 90-days of the date I sign this application. In such instance, John Hancock will notify me that my application has been disapproved.

I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid prior to the policy's effective date. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.) I understand that in order to keep my policy in force, I must pay all the required premiums when due.

Acknowledgments: I have received the policy Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure Form, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacement is involved). If eligible for Medicare, I have received the "Guide to Health Insurance for People with Medicare".

---

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

---

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

Signed at: \_\_\_\_\_  
City State Signature of Applicant Date

## Part 8 – Producer/Agent's Statement

### Interview:

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

### Replacement:

To the best of my knowledge, replacement of other insurance  is /  is not involved in this transaction. Listed below are all other health insurance policies I 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:** I have reviewed the Underwriting Guidelines and the information provided in this Application.

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

Signature of Licensed Agent: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_ State Where Signed: \_\_\_\_\_

## Credit for Application

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

JH Producer Payroll Number (Agent #): \_\_\_\_\_

Contract Code (JHFN Career Only): \_\_\_\_\_

Producer's Social Security # or Tax ID #: \_\_\_\_\_

Market Code: \_\_\_\_\_

Level Code: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_

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

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

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

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

If more than one Agent was involved in the sale of this application, provide details below:

Agent Name:	JH Producer Payroll #:	SS# or Tax ID#:	Percentage:

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

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

4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**
  - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
  - (b) **WAIVER OF PREMIUM.** We will waive the payment of premiums under this Policy if You have received services for which benefits are payable under the 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 \_\_\_\_\_

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**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 incidental 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.

**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:
  - Home Modifications;
  - Emergency Medical Response Systems;
  - Durable Medical Equipment;
  - Caregiver Training;
  - Home Safety Check; and
  - 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.

- **Alternate Services Benefit.** The Alternate Services Benefit allows You to use Your Policy's benefits to cover long-term care services not expressly covered by the Policy. Such services must be less expensive than the amount We would otherwise pay for such long term care services. The Alternate Plan of Care as well as the benefit levels to be payable, must be agreed upon by You and Us.
- **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 or You Elected FamilyCare.]*

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.

- **[FamilyCare.** The Family Care benefit allows You to cover up to 3 additional family members as Covered Persons. Eligible family members are able to access available benefits under the Long-Term Care Benefit, the Stay at Home Benefit, the Respite Care Benefit and the Care Advisory Services Benefit. There is not a separate Elimination Period to be met for each family member. In addition, the Waiver of Premium Benefit will be applied if You or any other family member are receiving benefits (with the exception of Respite Care, Care Advisory Services and Stay at Home Benefits). Multiple individuals can claim at the same time however, benefits are subject to the LTC Benefit Amount. All benefits are payable to You. As a reminder, You may assign benefits to a family member or a family member's care provider.
- **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 of Premium 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. In the event that You do not elect the Nonforfeiture Benefit, Your Policy will contain the Contingent Nonforfeiture Benefit provision. The Contingent Nonforfeiture Benefit provides that in the event We increase rates by more than a specified amount shown in the Contingent Nonforfeiture provision, We will provide You with the opportunity to: pay the increased premium, decrease Your benefits to a level supported by Your current premium, or elect the Contingent Nonforfeiture Benefit. Under the Contingent Nonforfeiture Benefit, Your Policy will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This means that a reduced benefit will be payable instead of the full Policy Limit.]

## 10. LIMITATIONS AND EXCLUSIONS

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

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

- for intentionally self-inflicted injury.
- 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 not reimbursable by Medicare such as 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 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.
- (d) **Coordination with Other John Hancock Individual Long-Term Care Insurance Policies.** We may reduce benefits payable under this Policy for Long-Term Care Services if We also pay benefits for such services under any other individual long-term care policy issued by Us. This includes policies providing Nursing Home, Assisted Living Facility and/or Home Health Care coverage whether payable on an expense reimbursement, indemnity or any other basis. Benefits will be reduced under this Policy, only when payment under this Policy and all other John Hancock individual long-term care policies combined would exceed the actual amount You incur for Long-Term Care Services. In no event will We pay under this Policy more than the difference between Your actual expenses and the amount payable by Your other policies with Us.

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

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

Because the costs of long-term care services will likely increase over time, You should consider whether and how the benefits of this Policy may be adjusted. The benefit level(s) of this Policy will not increase over time, unless You have elected to purchase Inflation Coverage. You are guaranteed the option to buy Inflation Coverage. The Policy contains the option to purchase: CPI Compound Inflation Coverage; 5% Compound Inflation Coverage; 5% Simple Inflation Coverage; or a Guaranteed Purchase Option. These options are described at the end of this Outline of Coverage.

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

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

**13. PREMIUMS**

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

**Annual Premium**

Base Policy (includes inflation, if any)	\$ _____
• [Family Care	\$ _____
• SharedCare	\$ _____
• Survivorship-Waiver of Premium 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.

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.**

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

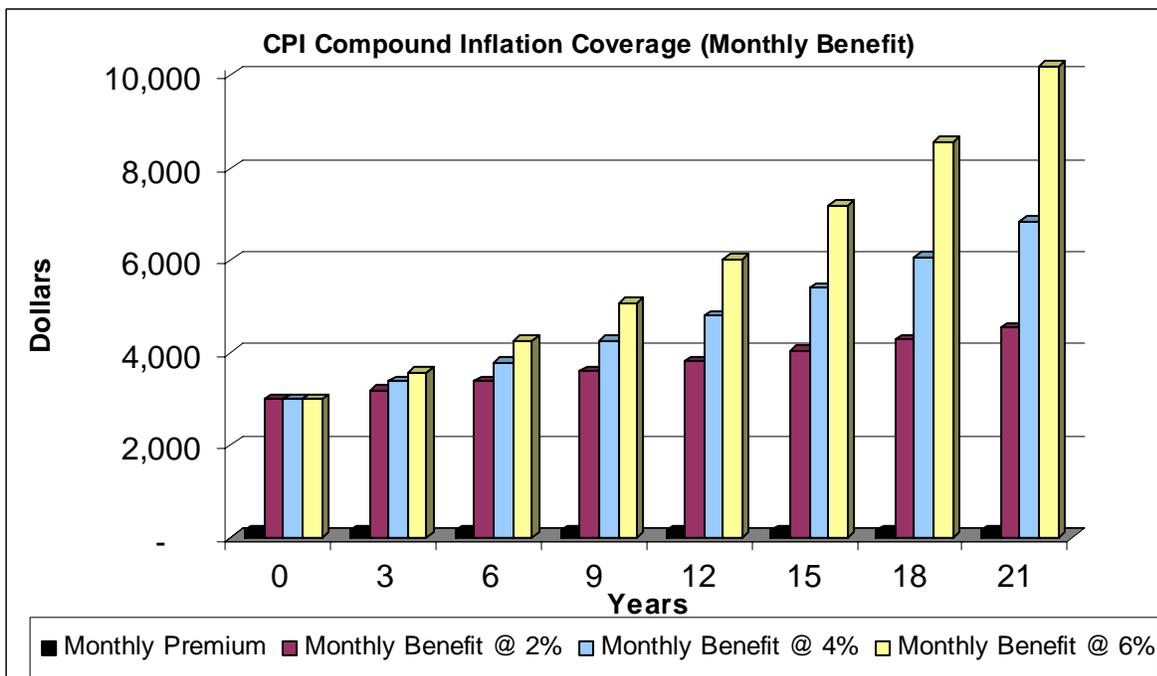
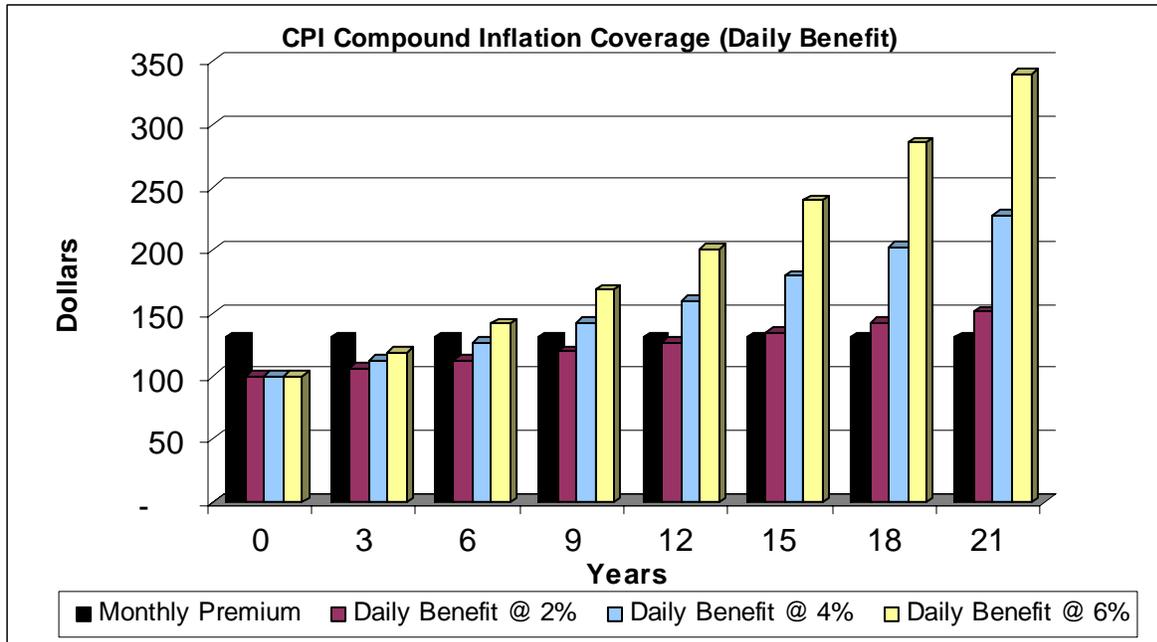
**CPI Compound Inflation Coverage and Guaranteed Increase Option**

**CPI Compound Inflation Coverage:** Under this option, Your Long Term Care Benefit Amount will be increased on each Policy anniversary by the percentage change in the non-seasonally adjusted Consumer Price Index (CPI) three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long Term Care Benefit Amount. The premium for the CPI Compound Inflation Coverage is included in the Policy premium. Your premium will not change for any annual automatic CPI compound increase, except as described in the Policy.

**Guaranteed Increase Option:** *(Important Notice – The Guaranteed Increase Option is not applicable to You if: You are paying Your premium via the Ten-Year Premium Payment Option or the Paid-Up at Age 65 Payment Option; or if You have elected the Survivorship and Waiver of Premium Benefit or Family Care Benefit.)* Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the Long Term Care Benefit Amount that was in effect immediately prior to that Option Date. This increase is in addition to the annual automatic CPI compound increase described above. No additional underwriting will be required. If You elect an increase under the Guaranteed Increase Option, the amount of the annual automatic CPI compound increase on that Option Date will be based on Your Long Term Care Benefit Amount prior to this additional purchase.

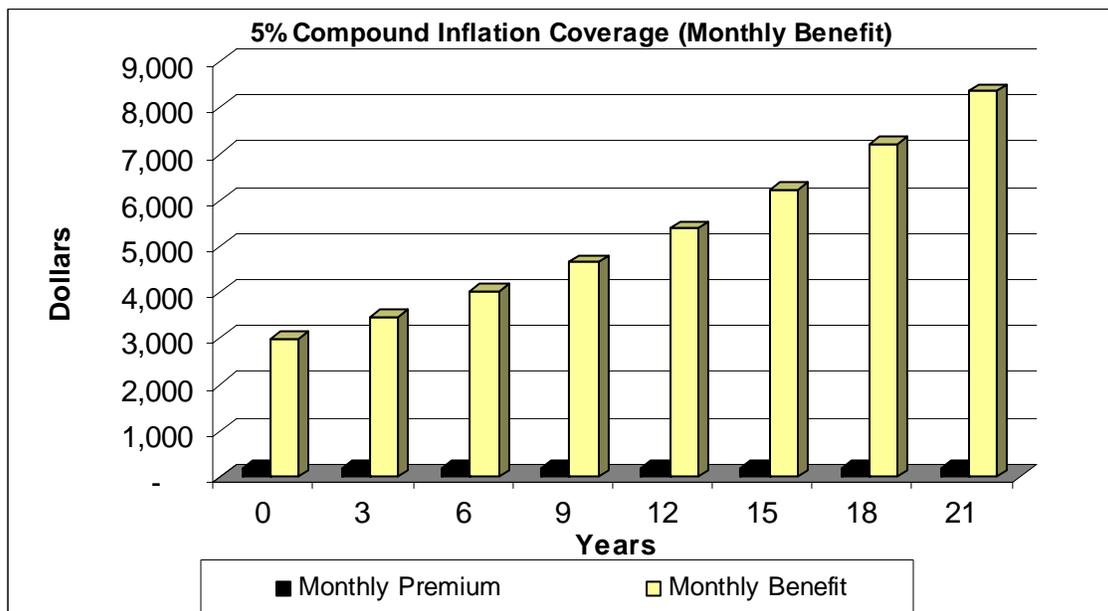
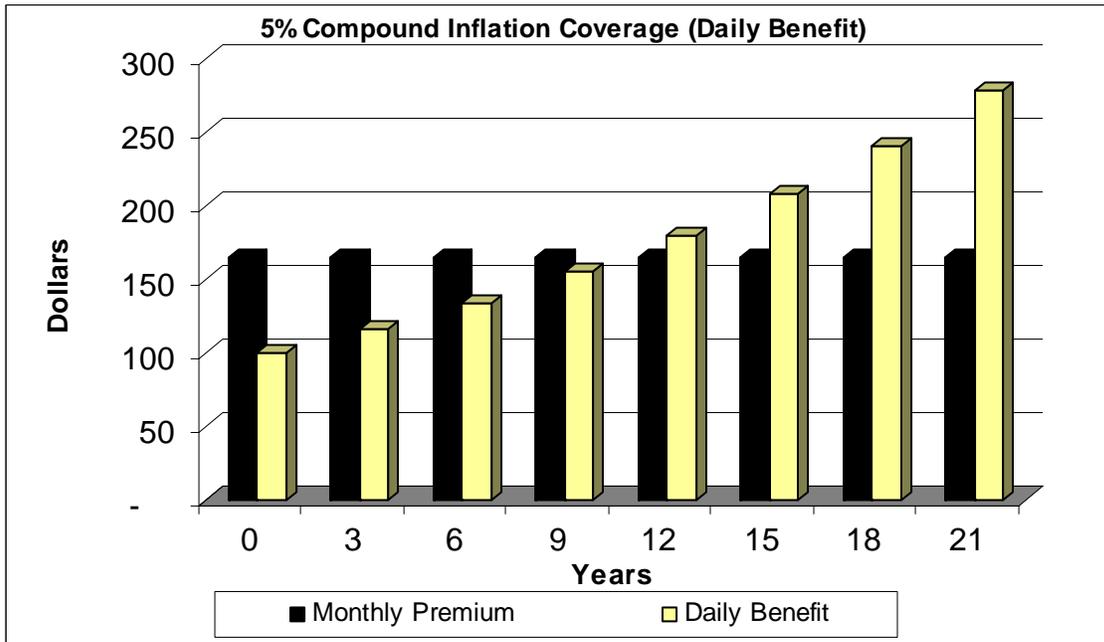
We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire. The premium for any increase under this Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect. The increase on any Option Date will not be available to You (and, if requested, will not take effect) if: any benefits have been payable under Your Policy during the two year period prior to the Option Date; or the Option Date occurs on or after Your 91st birthday.

The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under three possible scenarios – increases in coverage assuming a constant 2%, 4% or 6% change in the CPI. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long Term Care Benefit Amount of \$3,000 or daily Long Term Care Benefit Amount of \$100, and a 3-year Benefit Period.



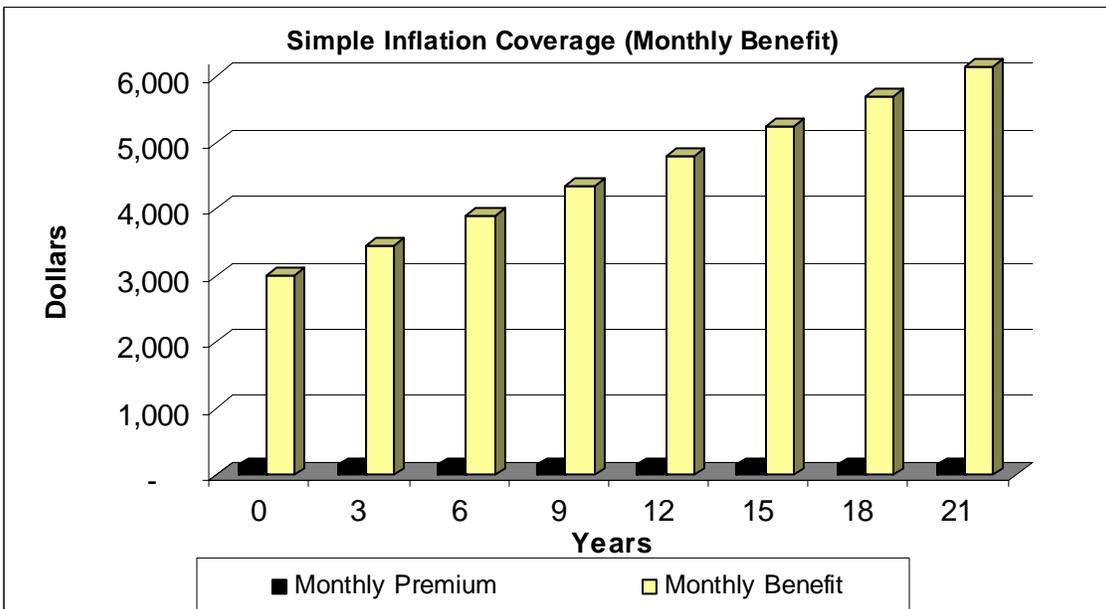
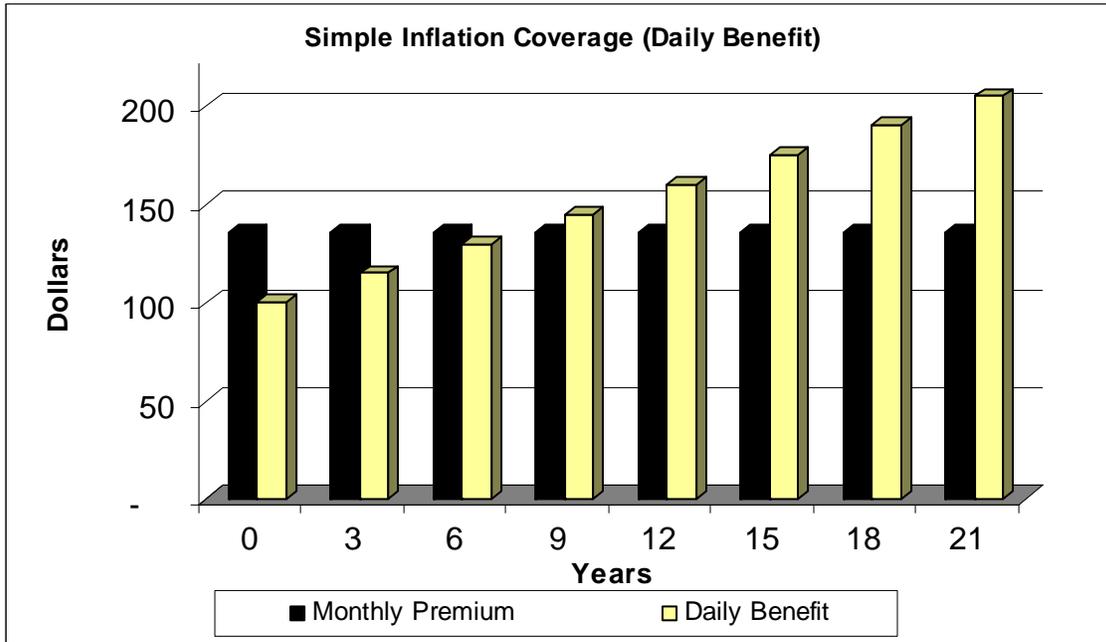
**5% Compound Inflation Coverage.** Your Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care Benefit Amount in effect during the prior Policy year. The annual increase is automatic and will occur on each Policy anniversary. The premium for 5% Compound Inflation 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 5% 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.



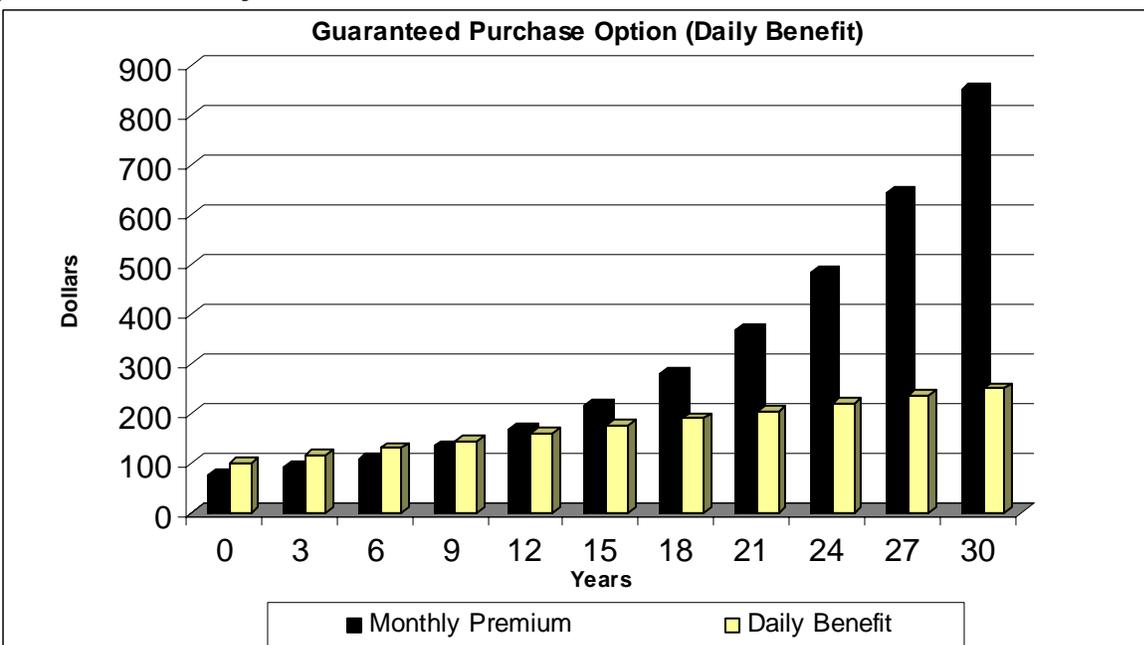
**5% Simple Inflation Coverage.** Your Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care Benefit Amount in effect when the Policy was issued. This annual increase is automatic and will occur on each Policy anniversary. The premium for 5% Simple Inflation Coverage 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 5% 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.



**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 or CPI 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 or CPI Compound Inflation Coverage and Your Guaranteed Purchase Option coverage at your attained age for Your then current benefits. If You elect to switch to 5% Compound or CPI Compound Inflation Coverage, You will not receive any future Guaranteed Purchase Option offers.

The graphs below 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 5% Compound Inflation Coverage.)





## John Hancock Life Insurance Company

### Additional Consumer Protection Provisions

This Endorsement is made part of and should be attached to Your Policy. It is subject to all the provisions, conditions and limitations of the Policy unless otherwise provided below.

1. The following provision is added to the end of the YOUR LONG-TERM CARE BENEFITS section of Your Policy.

#### **Alternate Services Benefit**

The Alternate Services Benefit may cover long-term care services not expressly covered by the Policy so long as all the requirements of this provision are met.

We will consider paying actual charges for alternate services under the Alternate Services Benefit only if: We determine You are eligible for benefits under this Policy, and the alternate services are:

- an alternative to Long-Term Care Services which You would otherwise require, that is less expensive than the amount We would otherwise pay for such Long-Term Care Services; and
- medical or non-medical professional or personal care services to assist You in the Activities of Daily Living or to provide supervision needed because of Your Cognitive Impairment; and
- necessary for You based upon Your medical status, current and future care plans, and suitability and effectiveness of care; and
- included in Your Plan of Care; and
- agreed upon by You and Us.

If We determine that You are eligible for the Alternate Services Benefit, the alternate services will be described in an alternate services agreement that is mutually agreed to in writing by You and Us. Such agreement will specify the maximum amount that We will reimburse for such services. We will only pay for alternate services received on or after the effective date of the alternate services agreement. In addition, Your Policy must be in effect when the charges for alternate services are incurred.

Any benefits paid under this provision will reduce Your Policy Limit. Days for which You receive alternate services on or after the effective date of the alternate services agreement will count toward the Elimination Period. We will not pay this benefit until Your Elimination Period has been satisfied.

The Alternate Services Benefit may not be used to pay for any charges for services described in the Charges Not Covered or Exceptions provisions of the Policy. In addition, the Alternate Services Benefit may not be used to supplement existing coverage limits under this Policy.

You may choose to discontinue the use of Alternate Services Benefits at any time.

Payment of the Alternate Services Benefit does not waive any of Your or Our rights under the Policy.

2. The provision captioned "Time of Payment of Claims" found in the CLAIMS section of Your Policy is deleted in its entirety and replaced with the following provision.

#### **Time of Payment of Claims**

Benefits under this Policy are payable after services have been rendered and charges have been incurred for such services.

We will send claim payment no later than 30 days after We receive notice of claim and Proof of Loss, provided that all Policy requirements have been satisfied. If We take more than 30 days to send the claim payment, We will pay interest on the amount of the claim that should have been paid, beginning 31 days after receiving all required information, until payment is made. Interest will be at the rate of 1% per month (or a higher rate if required by state law or regulation).

3. The following provision is inserted into the CLAIMS section of Your Policy following immediately after the provision captioned "Appeals".

#### **Independent Third Party Review**

You have the right to request an Independent Third Party Review if the Claim Appeals Review Board upholds a denial of Your claim based upon a determination that You do not need:

- Substantial Assistance to perform at least two Activities of Daily Living; or
- Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

We will provide You with written instructions on Your right to request an Independent Third Party Review when we notify you of the Claim Appeals Review Board's decision. You must make a request for an Independent Third Party Review in writing no later than 60-days after the date of Our notice informing You of the Claim Appeals Review Board's decision. The role of the Independent Third Party is to review relevant material related to the denial of Your claim that We provide. You will not undergo an exam. The Independent Third Party will provide both You and Us with written notice of its final decision. The decision of the Independent Third Party is final and binding on Us.

We will pay the costs associated with an Independent Third Party Review.

The Independent Third Party must be either:

- mutually agreed to by You and Us; or
- state approved or certified to conduct such reviews if the state requires such approvals or certifications.

In addition, an Independent Third Party must:

- be, or have on staff or contract with a qualified and licensed health care professional in an appropriate field for determining an individual's ability to perform the Activities of Daily Living or an individual's Cognitive Impairment, whichever applies to Your claim;
- not be affiliated with nor in any manner related to an entity or individual that previously provided care or services to You;
- not employ a licensed health care professional who is associated with Us or related to You in any manner; and
- not be compensated in any manner that is dependent upon the outcome of the review.

### **Termination**

This Endorsement will terminate when the Policy terminates.

Signed for the Company at Boston, Massachusetts:

A handwritten signature in cursive script that reads "Emanuel Alves".

Secretary

# Outline of Coverage

Long Term Care Insurance  
Policy Series LTC-06

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

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

4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**
  - (a) **RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE.** This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.
  - (b) **WAIVER OF PREMIUM.** We will waive the payment of premiums under this Policy if You are receiving services for which benefits are payable under the Long Term Care Benefit. The waiver period will start the day after You have satisfied 100 Dates of Service and will end on the date when benefits are no longer payable. The premium will not be waived, however, if benefits are only being received under the Additional Stay at Home Benefit.
5. **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:	Applicant A	Applicant B
<ul style="list-style-type: none"> <li>• [Long Term Care Benefit Amount                             <ul style="list-style-type: none"> <li>• <u>Monthly Benefit</u> \$1,500 to \$15,000 in \$100 increments</li> <li>• <u>Daily Benefit</u> \$50 to \$500 in \$10 increments</li> </ul> </li> </ul>	\$ _____	\$ _____
<ul style="list-style-type: none"> <li>• <b>Benefit Period</b> 3-year, 5-year or 5-year Plus* * The 5 Plus option is a 5-year Benefit Period plus \$1,000,000</li> </ul>	_____	_____
<ul style="list-style-type: none"> <li>• <b>Elimination Period</b></li> </ul>	100 Dates of Service	100 Dates of Service
<ul style="list-style-type: none"> <li>• <b>Inflation Protection</b></li> </ul>		
<ul style="list-style-type: none"> <li>• Automatic Inflation Coverage</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• 5% Compound Guaranteed Purchase Inflation Coverage</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• <b>Optional Benefits Selected</b></li> </ul>		
<ul style="list-style-type: none"> <li>• SharedCare</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• 0-Day Elimination Period for Home Health Care &amp; Adult Day Care</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>• Nonforfeiture</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>

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

- (a) **Long Term Care Benefit.** Subject to Policy requirements and limitations, this Policy provides coverage for actual charges up to the Long Term Care Benefit Amount incurred by:
- Your confinement in a Nursing Home or Assisted Living Facility for Your room, board and care services (such care services being Nursing Care, Custodial Care and Hospice Care);
  - Home Health Care (including homemaker services), Hospice Care, Respite Care; or
  - attendance at an Adult Day Care Center providing Adult Day Care.

Please note the following:

- The Elimination Period shall not apply to Hospice Care. During Your Elimination Period, actual charges incurred for Hospice Care up to the Long Term Care Benefit Amount are payable under the terms of this Policy.

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

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

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

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

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

- *Assessment and Certification.* The Care Coordinator will conduct an assessment to determine Your status and needs. The assessment encompasses a wide range of factors that make Your situation unique, such as Your functional, cognitive, behavioral, and emotional well-being, as well as family support and the safety of Your environment. This assessment of Your needs will form the basis of the Care Coordinator's Certification that You are a Chronically Ill Individual and Your Plan of Care.
- *Development of Your Plan of Care.* The Care Coordinator will work with You, Your Physician, Your family or Your representative, to develop a Plan of Care. This is a collaborative process. The Plan of Care will describe the type and frequency of services that will meet Your needs as identified in the assessment.
- *Coordinating Service Delivery.* The Care Coordinator may assist You in securing the services recommended in Your Plan of Care as necessary. The Care Coordinator will provide You with information on provider resources local to You, community programs, and health information resources.
- *Monitoring.* After You begin to receive services through Your Plan of Care, We will periodically check with You, Your family and Your providers to: re-assess Your current condition; monitor and assess the care You are receiving; determine whether Your Plan of Care continues to be appropriate; and recommend any necessary changes. This re-assessment will occur at least once a year (or more frequently as We determine appropriate) in order to provide You with the required annual Certification and to update Your Plan of Care as needed.

If You choose not to access the Care Coordination Benefit or are receiving care or services outside the 50 United States and the District of Columbia, You must arrange for Your Physician or another Licensed Health Care Practitioner to certify that You are a Chronically Ill Individual and prepare a Plan of Care for You at Your own expense. You must submit all Certifications and Plans of Care to Us. Please see the Claims section of the Policy for more details.

(c) **Additional Benefits.**

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

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

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

- **Alternate Services Benefit.** The Alternate Services Benefit allows You to use Your Policy's benefits to cover long-term care services not expressly covered by the Policy. Such services must be less expensive than the amount We would otherwise pay for such long term care services. The Alternate Plan of Care as well as the benefit levels to be payable, must be agreed upon by You and Us.

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

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

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

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

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

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

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

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

- [**SharedCare.** The SharedCare Rider allows Your Partner to access benefits under Your Policy if Your Partner first exhausts the available benefits payable under his or her policy. You and Your Partner may both receive benefits under Your Policy at the same time. In no event will We pay benefits that exceed the maximum Policy Limits of both policies combined. Your Partner must also have added an identical SharedCare Benefit Rider to his/her policy naming You as the Covered Person for that policy.

- **0-Day Elimination Period for Home Health Care and Adult Day Care.** We will waive the requirement that you satisfy the Elimination Period if You are receiving Home Health Care or Adult Day Care. The Elimination Period must still be satisfied before benefits are payable under Long Term Care Benefit for confinement in a Nursing Home or an Assisted Living Facility. However, days which the Home Health Care Elimination Period is waived will count toward meeting the facility Elimination Period.
- **Nonforfeiture Benefit.** If Your Policy lapses because You have not paid the premium within the Grace Period, after being in force at least three years (or one-year if You elect a limited pay option), it will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. In the event that You do not elect the Nonforfeiture Benefit, Your Policy will contain the Contingent Nonforfeiture Benefit provision. The Contingent Nonforfeiture Benefit provides that in the event We increase rates by more than a specified amount shown in the Contingent Nonforfeiture provision, We will provide You with the opportunity to: pay the increased premium, decrease Your benefits to a level supported by Your current premium, or elect the Contingent Nonforfeiture Benefit. Under the Contingent Nonforfeiture Benefit, Your Policy will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This means that a reduced benefit will be payable instead of the full Policy Limit.]

## 10. LIMITATIONS AND EXCLUSIONS

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

- (a) **Exclusions.** This Policy does not cover care, treatment or charges:
- for intentionally self-inflicted injury.
  - 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 Care Center or organization which is providing the services;
    - the organization receives the payment for the services; and
    - the family member receives no compensation other than the normal compensation for employees in his or her job category.
  - provided outside the fifty United States and 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 not reimbursable by Medicare such as 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 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 (except as described in the Additional Stay at Home Benefit); transportation; items and services furnished at Your request for beautification, comfort, convenience or entertainment; room and board charges for independent living quarters in a Continuing Care Retirement Community or similar entity; any type of residential upkeep, construction, renovation, or home maintenance (such as painting or plumbing); lawn/yard care; snow removal; or vehicle or equipment upkeep; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

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

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

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

Because the costs of long term care services will likely increase over time, this Policy includes inflation protection. You may select the inflation protection that best suits Your needs. You should consider whether and how the benefits of this Policy may be adjusted. You may elect Automatic Inflation Coverage or 5% Compound Guaranteed Purchase Inflation Coverage. These options are described at the end of this Outline of Coverage.

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

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

**13. PREMIUMS**

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

<b>Annual Premium:</b>	<b>Applicant A</b>	<b>Applicant B</b>
[Base Policy (includes inflation coverage)]	\$ _____	\$ _____
• Optional Benefits Selected:		
• SharedCare	\$ _____	\$ _____
• 0-Day Elimination Period for Home Health Care & Adult Day Care	\$ _____	\$ _____
• Nonforfeiture	\$ _____	\$ _____
<b>Total Annual Premium</b>	\$ _____	\$ _____
	Your premium will be \$ _____ on a _____ basis.**	Your premium will be \$ _____ on a _____ basis.**]

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

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

14. **ADDITIONAL FEATURES**

- (a) Issuance of Your coverage may depend upon certain medical information about You. This is generally known as medical underwriting.
- (b) This Policy provides added protection against lapse. You may name another person on the application to receive a termination notice 30 days after the premium due date. If Your Policy terminates because You did not pay a premium while You would meet the eligibility requirements for the payment of benefits, it may be reinstated within 5 months of the date of termination if:
  - You give Us proof of the Cognitive Impairment or Your inability to perform 2 of the Activities of Daily Living without Substantial Assistance; and
  - You pay all the unpaid overdue premiums.
- (c) This Policy includes an International Coverage Benefit. The International Coverage Benefit provides that we will pay actual charges incurred for covered Long Term Care Services up to the International Coverage Benefit for care received outside the United States. The International Coverage Benefit will not be paid in excess of an amount equal to: 365-times the Long Term Care Benefit Amount if You elected the daily Benefit Amount option; or 12-times the Long Term Care Benefit if You elected the monthly Benefit Amount option.
- (d) You may request an increase or decrease to Your coverage by contacting Us in writing. We will provide you with information and instructions regarding available options.

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.**

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**INFLATION PROTECTION AVAILABLE FOR YOUR LONG TERM CARE INSURANCE POLICY**

**Automatic Inflation Coverage and Guaranteed Increase Option**

**Automatic Inflation Coverage:**

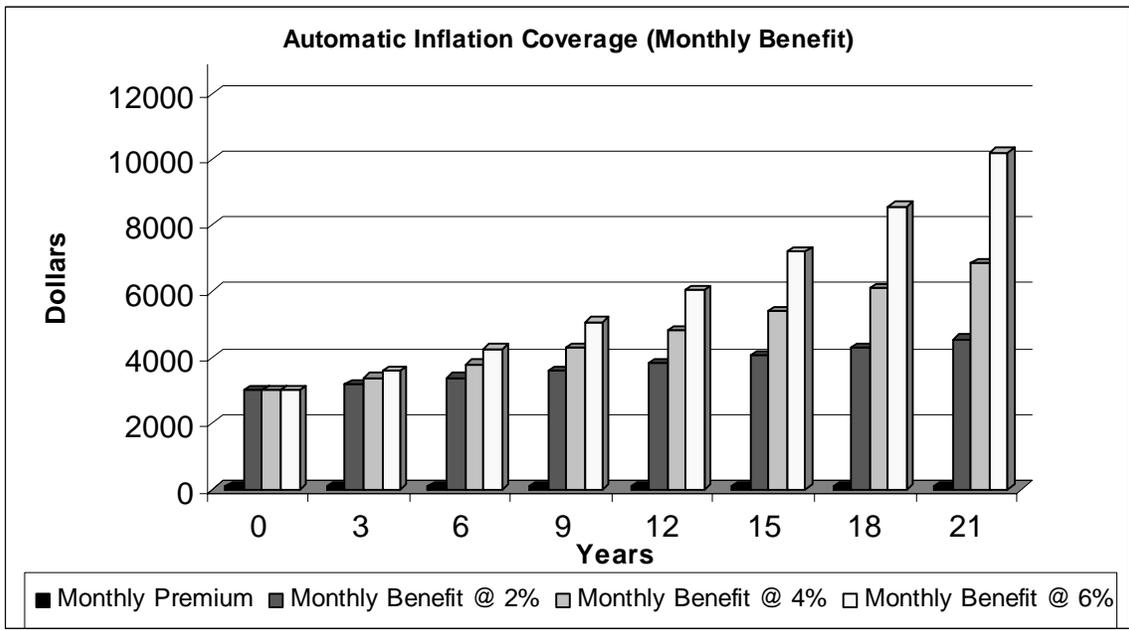
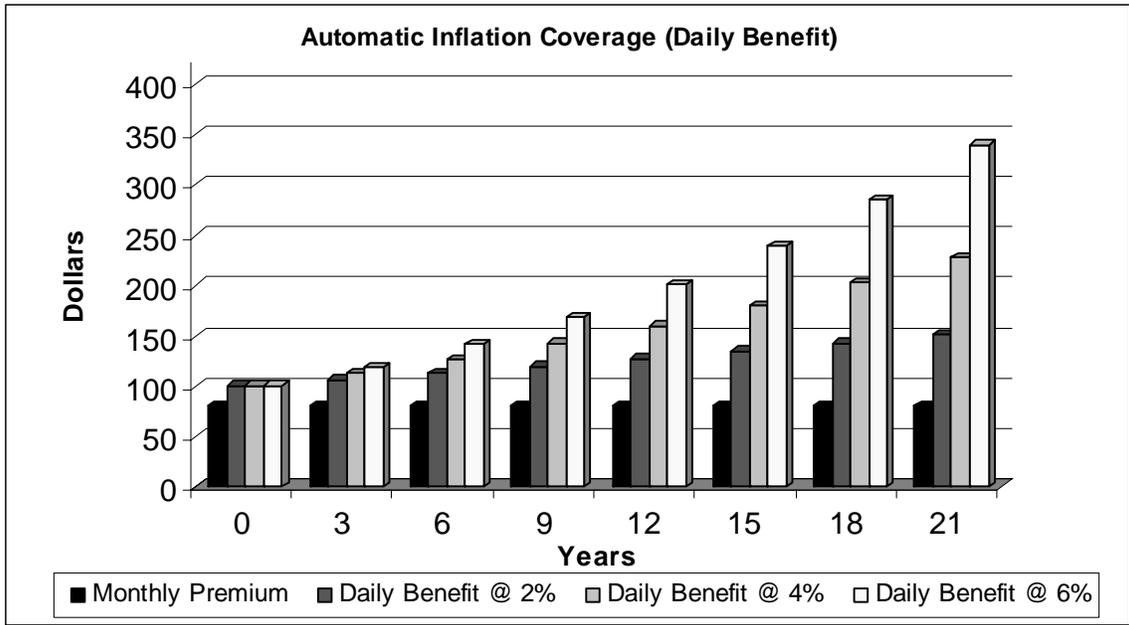
Under this option, Your Long Term Care Benefit Amount will be increased on each Policy anniversary by the percentage change in the non-seasonally adjusted Consumer Price Index (CPI) three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest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

**Guaranteed Increase Option:** *(Important Notice – The Guaranteed Increase Option is not applicable to You if You are paying Your premium via the Ten-Year Premium Payment Option or the Paid-Up at Age 65 Payment Option.)*

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the Long Term Care Benefit Amount that was in effect immediately prior to that Option Date. This increase is in addition to the annual automatic CPI increase described above. No additional underwriting will be required. If You elect an increase under the Guaranteed Increase Option, the amount of the annual automatic CPI increase on that Option Date will be based on Your Long Term Care Benefit Amount prior to this additional purchase.

We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire. The premium for any increase under this Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect. The increase on any Option Date will not be available to You (and, if requested, will not take effect) if: any benefits have been payable under Your Policy during the two year period prior to the Option Date; or the Option Date occurs on or after Your 91st birthday.

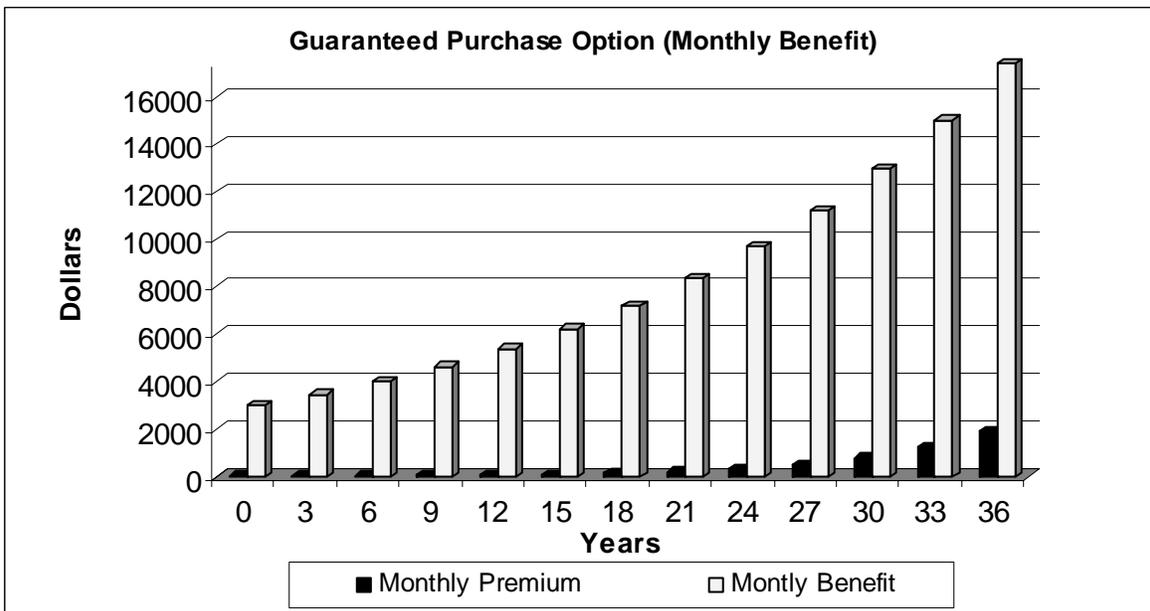
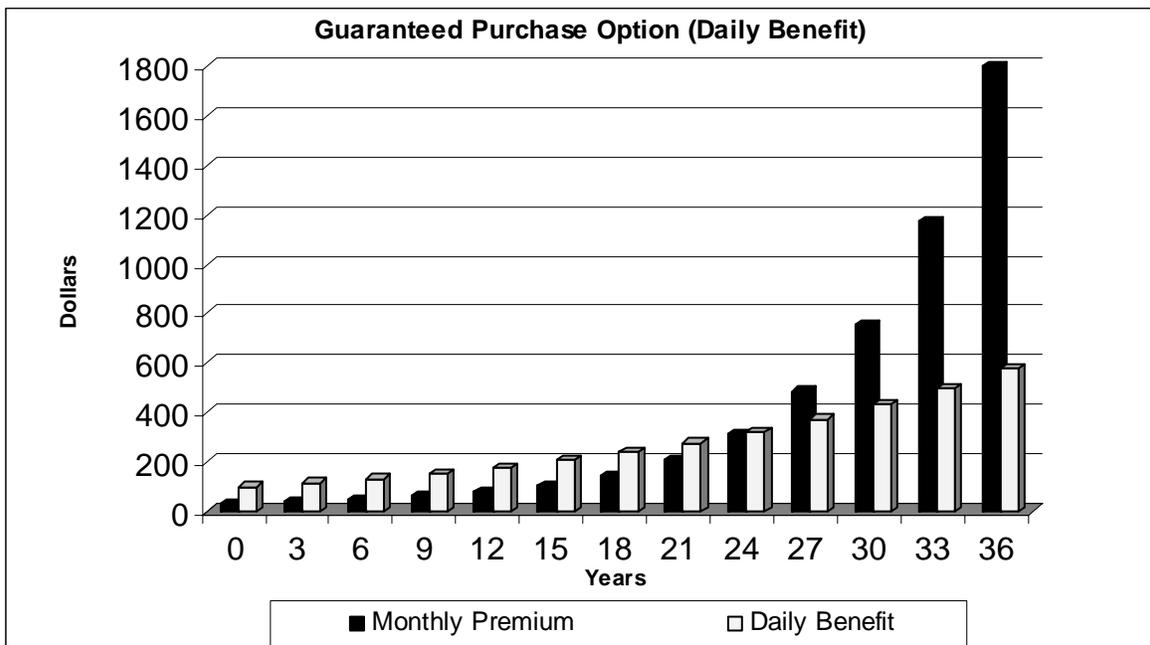
The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under three possible scenarios – increases in coverage assuming a constant 2%, 4% or 6% change in the CPI. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long Term Care Benefit Amount of \$3,000 or daily Long Term Care Benefit Amount of \$100, and a 3-year Benefit Period.



**5% Compound Guaranteed Purchase Inflation Coverage.** Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), You may elect to increase Your current Long Term Care Benefit Amount by 15.8% (5% compounded annually over 3 years) and rounded to the nearest dollar. No additional underwriting will be required. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

If You do not elect an increase when offered, that increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers unless You decline the offer two times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. The premium for each increase will be based on Your age on the Option Date and the premium rates then in effect.

The graphs below 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 50 and has chosen a monthly Long Term Care Benefit Amount of \$3,000 or daily Long Term Care Benefit Amount of \$100, and a 3-year Benefit Period. Assume the person has elected every increase offer.

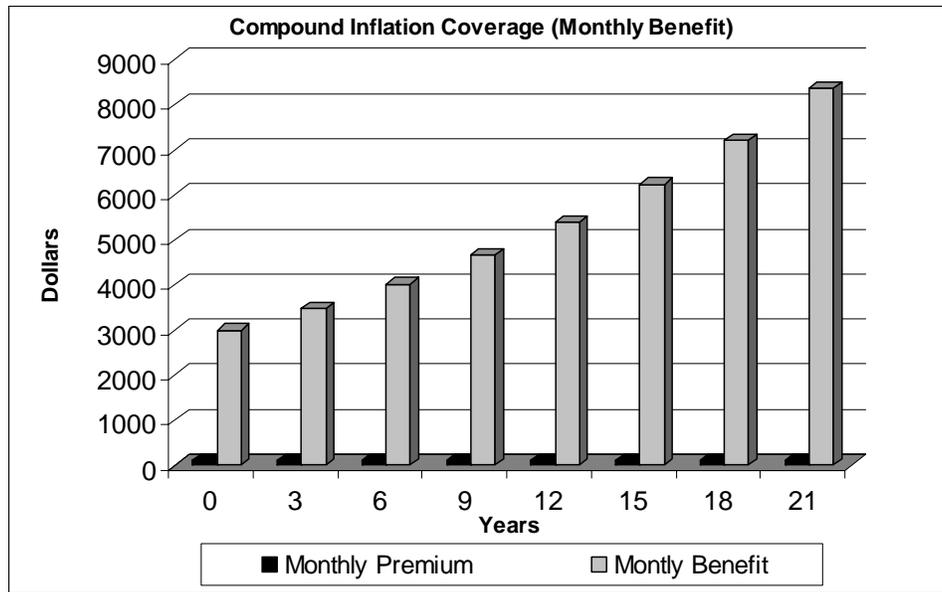
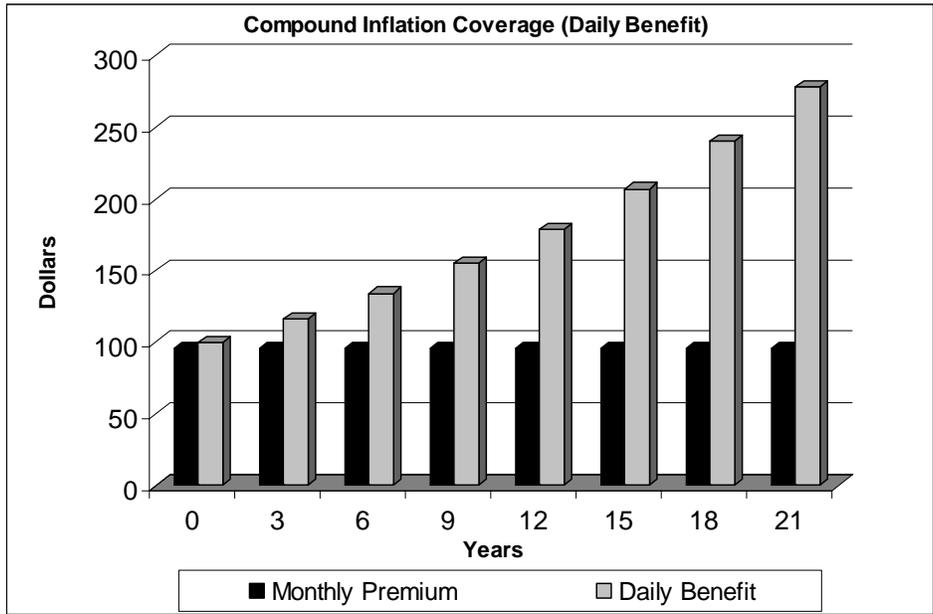


## IMPORTANT NOTICE REGARDING THE AVAILABILITY OF A POLICY WHICH INCLUDES 5% COMPOUND INFLATION PROTECTION

John Hancock also offers a separate policy with the 5% compound inflation option. Please ask Your producer or contact Us for more information if You are interested in learning more about this policy.

Under the 5% Compound Inflation Coverage option, the 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. The 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 50 and has chosen a monthly Long Term Care Benefit Amount of \$3,000 or daily Long Term Care Benefit Amount of \$100, and a 3-year Benefit Period.





## John Hancock Life Insurance Company

### Endorsement

This Endorsement is a part of, and should be attached to Your Policy. It is subject to all the provisions of the Policy unless otherwise provided below. This provision will remain in effect so long as You continue to pay Your Policy premium through a Limited Payment Option.

#### Limited Payment Option Contingent Nonforfeiture Benefit

In addition to any Nonforfeiture or Contingent Nonforfeiture Benefit that may be available to You under the Policy, You are eligible for the Limited Payment Option Contingent Nonforfeiture Benefit when all of the following requirements are met:

- We increase Your premium to a level which results in a cumulative increase which equals or exceeds the percentage of Your initial premium shown in the table below based on Your issue age;

<b>Triggers for a Substantial Premium Increase</b>	
<b><u>Issue Age</u></b>	<b><u>Cumulative Percent Increase Over Initial Premium</u></b>
Under 65	50%
65-80	30%
Over 80	10%

- You lapse (stop paying Your premiums) within 120 days of when the premium increase took effect; and
- The number of months that premiums have been paid on this policy is equal to or greater than 40% of the number of months that premiums are payable .

If You exercise this option, Your coverage will be converted to reduced paid-up status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- The new daily or monthly Benefit Amount and remaining Policy Limit for Your reduced paid-up coverage will be determined by multiplying the amounts prior to the reduction by 90% times the ratio of the number of months that premiums have been paid divided by the number of months that premiums are payable.
- All other Benefit Amounts will also be adjusted by the same ratio.

No benefits will be paid in excess of the new coverage and policy limits. All optional benefit riders will automatically terminate when Your Policy changes to paid-up status under the provisions of this benefit. In addition, no inflation adjustment will be made while the Policy is in effect under this benefit. If You purchased lifetime benefits, only the daily (or monthly, if applicable) Benefit Amounts will be adjusted.

If You are eligible for the Limited Payment Option Contingent Nonforfeiture Benefit and another nonforfeiture benefit under the Policy, You may choose between either of the two benefits.

**Termination**

This Endorsement will terminate on the earlier of the following dates: the date You terminate Your Limited Payment Option; or the date when the Policy terminates.

Signed for the Company at Boston, Massachusetts:

A handwritten signature in black ink, appearing to read "Emanuel Alves". The signature is written in a cursive style with a large initial 'E' and 'A'.

Secretary

## Before You Buy

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

- Long-Term Care Insurance**
  - A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
  - You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
  - The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
- Medicare**
  - Medicare does **not** pay for most long-term care.
- Medicaid**
  - Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
  - Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
  - When Medicaid pays your spouse's nursing home bills you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
  - Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
- Shopper's Guide**
  - Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
- Counseling**
  - Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
- Facilities**
  - Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

# Long-Term Care Insurance Personal Worksheet

John Hancock Life Insurance Company



[Applicant A]

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

By state law, John Hancock Life Insurance Company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and us decide if you should buy this policy.

## PREMIUM INFORMATION

Policy Form Number:  LTC-03 or state equivalent  LTC-06 or state equivalent

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

Type of Policy: Guaranteed Renewable

## THE COMPANY'S RIGHT TO INCREASE PREMIUMS

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

## RATE INCREASE HISTORY

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

In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company (now known as Time 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	In 2003: 30% increase
All states (except AK, DC, HI, ID, IA, KS, MA, ME, MN, NJ, NM, NY and VT).	Policy series 4000, 4002, 4006, 4008, 4040, 4042 &/or 4043	1993 - 1997	In 2005: <ul style="list-style-type: none"><li>• 12% - 40% increase for series 4000, 4002, 4040, 4042, &amp;/or 4043 except in:<ul style="list-style-type: none"><li>○ LA, MI, NV &amp; SC where increase range was 39%-56%;</li><li>○ NC where increase range was 27% - 47%</li><li>○ VA where increase range was 88% - 110%</li></ul></li><li>• 27% - 47% increase for series 4006 &amp; 4008</li></ul>
GA, KS, MD & WI	Policy series 4040, 4042 & 4043; without associated riders 2020, 2021 (where applicable)	1993-1997	In 2007: 4040 Series: 8%-20% increase 4042 Series: 13%-25% increase 4043 Series: 5% increase GA only. ]

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

## QUESTIONS RELATED TO YOUR INCOME

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

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

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

- Yes       No

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 [2005] was [\$71,140], but this figure varies across the country. In ten years, the national average annual cost would be about [\$115,880] 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.

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

[Applicant A]

## 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.

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

Applicant [A's] Signature: **X** \_\_\_\_\_ Date \_\_\_\_\_

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

Agent's Signature: **X** \_\_\_\_\_ 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 [A's] Signature: **X** \_\_\_\_\_ Date \_\_\_\_\_

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

# Long-Term Care Insurance Personal Worksheet

John Hancock Life Insurance Company



[Applicant A]

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

By state law, John Hancock Life Insurance Company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and us decide if you should buy this policy.

## PREMIUM INFORMATION

**Policy Form Number:**  LTC-03 or state equivalent  LTC-06 or state equivalent

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

**Type of Policy:** Guaranteed Renewable

## THE COMPANY'S RIGHT TO INCREASE PREMIUMS

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

## RATE INCREASE HISTORY

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

In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company (now known as Time 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	In 2003: 30% increase
All states (except AK, DC, HI, ID, IA, KS, MA, ME, MN, NJ, NM, NY and VT).	Policy series 4000, 4002, 4006, 4008, 4040, 4042 &/or 4043	1993 - 1997	In 2005: <ul style="list-style-type: none"> <li>12% - 40% increase for series 4000, 4002, 4040, 4042, &amp;/or 4043 except in: <ul style="list-style-type: none"> <li>LA, MI, NV &amp; SC where increase range was 39%-56%;</li> <li>NC where increase range was 27% - 47%</li> <li>VA where increase range was 88% - 110%</li> </ul> </li> <li>27% - 47% increase for series 4006 &amp; 4008</li> </ul>
GA, KS, MD & WI	Policy series 4040, 4042 & 4043; without associated riders 2020, 2021 (where applicable)	1993-1997	In 2007: <ul style="list-style-type: none"> <li>4040 Series: 8%-20% increase</li> <li>4042 Series: 13%-25% increase</li> <li>4043 Series: 5% increase GA only. ]</li> </ul>

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

QUESTIONS RELATED TO YOUR INCOME

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

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

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

- Yes       No

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 [2005] was [\$71,140], but this figure varies across the country. In ten years, the national average annual cost would be about [\$115,880] 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.

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

[Applicant A]

## 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.

---

**◀ This box must be checked.** I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Applicant [A's] Signature:

X \_\_\_\_\_

Date \_\_\_\_\_

## Long Term Care Insurance Potential Rate Increase Disclosure Form

1. The premium rate that is applicable to you and that will be in effect until a request is made and filed and approved by your state insurance department for an increase is \$\_\_\_\_\_. (This premium rate is subject to change if you request a subsequent change in benefits, or if during the underwriting review of your application, it is determined that a premium rate adjustment is needed based upon your underwriting classification.)
2. The premium for this policy will be shown on the schedule page of your policy.
3. **Rate Schedule Adjustments:**

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

4. **Potential Rate Revisions:**

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

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

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

### \*Contingent Nonforfeiture

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

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

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

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

Applicant(s) Copy



## Long Term Care Insurance Potential Rate Increase Disclosure Form – (continued)

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

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

### Example:

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

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

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

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

Applicant(s) Copy



## Long Term Care Insurance Potential Rate Increase Disclosure Form – *(continued)*

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced “paid up” benefit **AND** the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced “paid up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

### Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; **AND**
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

**If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:**

- a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid-up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

*If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.*

### **Example:**

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

**Applicant(s) Copy**



**JOHN HANCOCK LIFE INSURANCE COMPANY**

**ENDORSEMENT**

**GUARANTEED PURCHASE OPTION**

**This Endorsement explains how Your Long-Term Care Benefit Amount may increase on each Option Date to provide protection against the increasing cost of long-term care.**

This Endorsement is part of, and should be attached to Your Policy. It is subject to all the provisions of the Policy unless otherwise provided below.

**Option Dates**

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage. You will be provided with a choice of electing an amount equal to 5, 10 or 15% of Your original Long-Term Care Benefit Amount. No additional underwriting will be required.

**If You do not elect all or any portion of an increase when offered, that increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers.**

**Guaranteed Purchase Option Increases**

Each offer of increase is subject to the following:

- You must send Us a written acceptance on the form that We will supply. Such acceptance must be sent to Us within 31 days after the Option Date.
- You will be provided with a choice of electing an amount equal to 5, 10 or 15% of Your original Long-Term Care Benefit Amount.
- The premium for any increase will be based on Your age on the Option Date and the premium rates then in effect.

If the Long-Term Care Benefit Amount is increased, then the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

In addition, in the event You accept an offer under the provisions of this Endorsement, there will be a corresponding additional premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy. Such additional premium will also be based on attained age rates for any additional benefits elected under this Endorsement.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- any benefits have been payable under Your Policy during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 91st birthday.

No Guaranteed Purchase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

**One-Time Offer to Switch to 5% Compound or CPI Compound Inflation Coverage On Your 65<sup>th</sup> Birthday**

***This provision applies to individuals under age 65.***

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 or CPI Compound Inflation Coverage. This offer will be available to You for a period of 60-days. Your election must be in writing on the form that We provide You. You must then send this form back to Our LTC Administrative Office. We will provide You notice of the new increased premium. The increase in Your premium will be equal to the difference between the premium for 5% Compound or CPI Compound Inflation Coverage and Your Guaranteed Purchase Option coverage at Your attained age for Your then current benefits.

The offer to switch Your Guaranteed Purchase to 5% Compound or CPI Compound Inflation will not be available to You (and, if requested, will not take effect) if any benefits have been payable under Your Policy during the two year period prior to the date this offer is made to You.

If You elect to switch to 5% Compound or CPI Compound Inflation Coverage, You will not receive any future Guaranteed Purchase Option offers.

**Termination**

This Endorsement will terminate when the Policy terminates, or when the Policy is continued under the provisions of any nonforfeiture benefit.

Signed for the Company at Boston, Massachusetts:



Secretary

*SERFF Tracking Number:*      *MULF-125419947*                      *State:*                      *Arkansas*  
*Filing Company:*              *John Hancock Life Insurance Company*              *State Tracking Number:*      *37807*  
*Company Tracking Number:*  
*TOI:*                      *LTC03I Individual Long Term Care*              *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *Long term care insurance- CCII 2008*  
*Project Name/Number:*      *CCII Enhanced 2008/*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MULF-125419947 State: Arkansas  
Filing Company: John Hancock Life Insurance Company State Tracking Number: 37807  
Company Tracking Number:  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: Long term care insurance- CCII 2008  
Project Name/Number: CCII Enhanced 2008/

## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Certification/Notice 01/08/2008  
**Comments:**  
**Attachment:**  
GenReadCert.pdf

**Review Status:**  
**Bypassed -Name:** Application 01/08/2008  
**Bypass Reason:** Please refer to Form Schedule tab for all applications.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Outline of Coverage 01/08/2008  
**Bypass Reason:** Please refer to Form Schedule tab for the Outlines of Coverage.  
**Comments:**

**Review Status:**  
**Satisfied -Name:** Cover Letter 01/08/2008  
**Comments:**  
**Attachment:**  
AR\_2008\_Cover\_letter.pdf

CERTIFICATION OF READABILITY

State of

Form Number

Flesch Readability Score

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of

\_\_\_\_\_.

\_\_\_\_\_  
Company

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date





## John Hancock Life Insurance Company

---

John Hancock Place  
Post Office Box 111 B-6-6  
Boston, Massachusetts 02117  
1-888-877-6065  
Direct: (617) 572-0281  
Fax: (617) 572-0399  
Email: [jwitham@jhancock.com](mailto:jwitham@jhancock.com)



**Joanne Witham**  
**Contract Consultant**  
**LTC Contracts and Legislative Services**

January 8, 2008

Julie Benafield Bowman  
Commissioner  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: **John Hancock Life Insurance Company**  
**Company NAIC # 65099, FEIN # 04-1414660**  
**Individual Long-Term Care Insurance Forms & Rates Submission**  
**Endorsements and Forms for Policy Forms LTC-03 AR and LTC-06 AR**  
**(See attached Forms List)**

Dear Commissioner:

We enclose copies of the forms listed above for your review and approval. A description of these forms is found below. These forms are new and will replace any prior versions that we currently have on file with your Department. These forms will be used with our Custom Care II policy form LTC-03 AR approved by your Department on 10/16/03. And Leading Edge policy form LTC-06 AR approved by your Department on 1/8/07. The effective date for the use of these forms will be April 1, 2008 or immediately following approval if later. The purpose of this filing is fourfold:

**Addition of Consumer Protection Provisions to our Portfolios** – We would like to add the following consumer protection provisions to our currently marketed product portfolio:

- a new Alternate Services Benefit.
- an enhancement to our Time of Payment of Claims provision.
- the addition of a new Independent Third Party Review provision.
- for Custom Care II (LTC-03 AR) only, we are also including a new enhancement which allows individuals to increase or decrease their coverage which is identical to our Leading Edge policy.

These features are included in endorsement Forms LTC-CPP1 1/08 for policy form LTC-03 AR and LTC-CPP2 1/08 for policy form LTC-06 AR. We have also revised the outlines of coverage for both policy forms, OCLTC-03 1/08 and OCLTC07-2 1/08.

**Addition of Automatic Inflation Coverage to our Custom Care II Portfolio** - We are also including the Automatic Inflation (LTC-2CPI/GIO 1/08) to be used with our LTC-03 AR policy form, which is identical to our already approved version LTC-CPI/GIO 6/07 (approved by your department 12/3/07), with the exception of the "Important Notice" section. As we are filing this new option, we would like to inform you that we will discontinue offering the 5/3 inflation option (LTC-3COMP 9/03), approved by your department on 10/16/06. Application forms CC2APP08 AR, CC2USAA08 AR, CC2MGTI08 AR and CC2SGRP08 AR and the outline of coverage OCLTC-03 1/08 reflect this additional options.

**2006 NAIC LTC Model Updates** - In accordance with the 2006 NAIC Long Term Care Model changes we are submitting new and revised forms. We have reviewed the changes and found that our portfolios only need to be updated in the areas relating to downgrades and contingent benefit for policies with limited payment options. The downgrade provision is included in submitted endorsement form LTC-CPP1 1/08 for LTC-03 AR. Please note the downgrade provision is already included in policy form LTC-06 AR so no addition is required to this form. We are submitting for approval the Contingent Nonforfeiture for policies with Limited Payment options LTC-LIMCNF 9/07, the Personal Worksheet (agent) LTC-PWK 1/08, the Personal Worksheet (direct) LTC-PWKDM 1/08, the Suitability Information Sheet LTC-SUIT 9/07 and Rate Increase Disclosure LTC-RII 9/07 that will be used with both policy forms.

**Submission of Supportive Actuarial Material** - As we have enhanced the policy benefits through the LTC-CPP1 1/08 endorsement, adjusted rates and the addition of the Automatic Inflation option to our policy LTC-03 AR, enclosed is the Actuarial Memorandum that reflects these changes. In addition, we are including an amendment to the LTC-06 AR to reflect the LTC-CPP2 1/08 endorsement, with no change in rates.

From time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/printed via website technology. Variable information is enclosed by brackets "[ ]" please see Appendix A for Statement of Variability.

This submission is being filed simultaneously in all 50 states and the District of Columbia.

The following items are included in this submission:

- the submission letter
- above referenced forms
- all required certifications.

Thank you for your time and consideration in this matter.

Sincerely,

A handwritten signature in cursive script that reads "Joanne Witham". The signature is written in black ink and is positioned to the right of the word "Sincerely,".

Joanne Witham  
Sr. Contract Consultant

## Forms List

Form Description	Policy Form LTC-03 AR	LTC-06 AR
Consumer Protection Endorsement	LTC-CPP1 1/08	LTC-CPP2 1/08
Automatic Inflation Application	LTC-2CPI/GIO 1/08	N/A
USAA Application	CC2APP08 AR	N/A
Corporate Solutions Application	CC2APPUSAA08 AR	N/A
Sponsored Group Application	CC2MGTI08 AR	N/A
Outline of Coverage	CC2SGRP08 AR	N/A
Contingent NF for Limited Pay Policies	OCLTC-03 1/08	OCLTC-07-2 1/08
Personal Worksheet (agent)	LTC-LIMCNF 9/07	LTC-LIMCNF 9/07
Personal Worksheet (direct)	LTC-PWK 1/08	LTC-PWK 1/08
Suitability Information Sheet	LTC-PWKDM 1/08	LTC-PWKDM 1/08
Rate Increase Disclosure	LTC-SUIT 9/07	LTC-SUIT 9/07
	LTC-RII 9/07	LTC-RII 9/07

## Appendix A – Statement of Variability

### Application CC2APP08 AR

- Brackets indicate items that may appear as shown or be omitted.
- Part 2 – certain sections of Part 2 could vary based upon marketing needs of distribution channels, the policy and optional benefit features offered.
- Part 7 – certain sections of Part 6 could vary based upon administration system or process developed for specific distribution channels.
- Part 10 - would be omitted in Direct Market channel.
- Credit for Application - would be omitted in Direct Market channel. In addition, the requested producer information may vary due to administrative platforms used or internal reporting requirements.

### Application CC2APPUSAA08 AR

- Part 3 – Some benefit options could be omitted. More importantly, with some channels, we may need to add our usual information regarding disallowed combinations. For example, Survivorship/Waiver (Not available with Limited Payment Options.)
- Part 4 - The Marital/Partner Discount section could vary based upon distribution channel, marketing needs or program features offered.
- Part 6 – Certain sections of Part 6 could vary based upon payment options available, administration system or process developed for specific programs or distribution channels.
- Part 7 – Some underwriting questions could be eliminated.
- Part 9 – The bracketed paragraph could be replaced by a paragraph appropriate to no advance payment.
- Part 10 - would be omitted in Direct Market channel.
- Credit for Application - would be omitted in Direct Market channel. In addition, the requested producer information may vary due to administrative platforms used or internal reporting requirements.

### Application CC2MGTI08AR & CC2SGRP08 AR

- Agent Use Only – This is an administrative section to be completed by the producer. Text may differ if needed for system coding requirements.
- Part 1 – This section is variable to allow for the selection of Custom Care II Enhanced benefits as the case may be. The full portfolio of benefits is shown on each submitted application. Benefits may be limited in some instances per the requirements of a particular distribution channel or sponsored group. In addition, the benefit selection may also include set parameters such as a choice in 2 or 3 set plan designs. Please note that in instances, all mandated inflation & nonforfeiture coverage offers as well as the required rejection language would always appear as shown.
- Part 2 - The Marital/Partner Discount and Business Information section could vary based upon distribution channel, marketing needs or program features offered.
- Part 3 – The instructions and subsections found in Part 3 are variable to reflect the inclusion or exclusion of particular sections based upon the marketing program, distribution channel selection or benefits selection. Instructions will be modified as needed to reflect such inclusions/exclusions. For example, if a limited range of benefit options are provided, subpart B may be deleted in their entirety. In addition, questions may be revised if a benefit to applicants. In no instance will any question/section be modified to the detriment of the applicant.
- Part 5 – Certain sections of Part 5 could vary based upon payment options available, administration system or process developed for specific programs or distribution channels.
- Part 7 –The time period shown in the next to last sentence in the first paragraph may range from 30 – 90 days. The 2<sup>nd</sup> paragraph may vary to recognize a requirement of money taken with the application.
- Part 8 – This section would be omitted in Direct Market channel.
- Credit for Application - would be omitted in Direct Market channel. In addition, the requested producer information may vary due to administrative platforms used or internal reporting requirements.

## FLESCH SCORE CERTIFICATION

The undersigned, as officer of the John Hancock Life Insurance Company, hereby certifies that each form in this filing meets the Flesch minimum reading ease score of 40.



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(Signed by Officer of Company)  
Marie Roche  
Assistant Vice President  
Long-Term Care Compliance

Date: January 8, 2008