

SERFF Tracking Number: MANU-126399004 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 44192
Company Tracking Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
Project Name/Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)/NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)

Filing at a Glance

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

Product Name: NB5000AR SERFF Tr Num: MANU-126399004 State: Arkansas
(11/2009)/NB5092AR (11/2009)/NB5120AR
(11/2009)/NB5011US (12/2007)

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 44192
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: NB5000AR State Status: Approved-Closed
(11/2009)/NB5092AR
(11/2009)/NB5120AR
(11/2009)/NB5011US (12/2007)

Filing Type: Form

Reviewer(s): Linda Bird
Authors: Helene Landow, Karren Disposition Date: 12/01/2009
Phair, Debbie Tom, Jacqueline Lau
Date Submitted: 11/25/2009 Disposition Status: Approved-Closed
Implementation Date:

Implementation Date Requested:

State Filing Description:

General Information

Project Name: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR Status of Filing in Domicile: Authorized
(11/2009)/NB5011US (12/2007)

Project Number: NB5000AR (11/2009)/NB5092AR
(11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Exempt in Michigan

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 12/01/2009

Explanation for Other Group Market Type:

State Status Changed: 12/01/2009

Deemer Date:

Created By: Debbie Tom

Submitted By: Debbie Tom

Corresponding Filing Tracking Number:

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Filing Description:

Re: John Hancock Life Insurance Company (U.S.A.) N.A.I.C. #904-65838

INDIVIDUAL LIFE

NB5000AR (11/2009) - Application for Life Insurance

NB5092AR (11/2009) - Application for Term Life Insurance – Single Life

NB5120AR (11/2009) - LifeCare Application for Life Insurance

NB5011US (12/2007) - Important Notice: Replacement of Life Insurance or Annuities (Model Regulation)

The above application forms are being submitted for your approval. These forms are being filed to comply with state requirements for replacements under Department Rule and Regulation 97 effective January 1, 2010. No part of this filing contains any unusual or controversial items that deviate from normal company or industry standards. The forms will be available electronically to print locally without change in the pre-formatted content.

Form NB5000AR (11/2009), Application for Life Insurance will replace form NB5000US (12/2007) which was approved by your state on February 11, 2008 under SERFF Tracking # MANU-125381606, State Tracking # 37810. Replacement question #7 on page 2 has been revised to refer to the appropriate question and notice form. 2 copies of form NB5000AR (11/2009) are enclosed, one marked to reflect the changed question 7 on page 2 and form number on all pages. In addition on page 1, we deleted companies “John Hancock Life Insurance Company” and “John Hancock Variable Life Insurance Company” including all checkboxes. We moved “Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 15)” and “Signature of Proposed Life Insured Two if other than Owner” to the right side and deleted “Signature of Witness or Agent/Registered Representative or Witness”, “Print Name – If Witness other than Agent/Representative” and “Witness Relationship – If Witness other than Agent/Registered Representative” on page 6 within the Signatures section.

Form NB5092AR (11/2009), Application for Term Life Insurance – Single Life will replace form NB5092US(04/2007) which was approved by your state on April 24, 2007 under SERFF Tracking # MANU-125158915, State Tracking #35692. Replacement question #7 on page 2 has been revised to comply with state Insurance Rule.

Form NB5011US (12/2007), Important Notice: Replacement of Life Insurance or Annuities (Model Regulation) is similar to the model form under Appendix A of Department Rule and Regulation 97 and will replace form NB5017US (12/2007) which was approved by your state on April 22, 2008 under SERFF Tracking # MANU-125598673, State Tracking #38705.

Form NB5120AR (11/2009), LifeCare Application for Life Insurance will replace form NB5120US (07/2009) which was approved by your state on August 21, 2009 under SERFF Tracking # MANU-126275171, State Tracking # 43291.

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Replacement question #4.a) on page 1 and replacement question #1 on page 6 has been revised to comply with state Insurance Rule.

Administrative Agent Report forms #NB5076US (01/2009) and NB5094US (10/2008) are being submitted for informational purposes. Form NB5094US (10/2008) contains the agent's replacement question under #3 and must be completed/submitted by the agent with each Application for Term Life Insurance form NB5092AR (11/2009). Form NB5076US (11/2009) contains the agent's replacement question under #6 a) and must be completed/submitted with each Application for Life Insurance form NB5000AR (11/2009).

The Service Office Address on the submitted forms is shown as variable information in [brackets] to accommodate any future changes.

We trust the forms are acceptable to you and look forward to your state's approval in the usual manner. If you have any questions or concerns, please contact me at 416-852-2035 (collect) or via email at debbie_tom@jhancock.com

- Enclosures: Statement of Variability
- Flesch Score Certificate
- Filing fee sent via EFT
- Copies of highlighted forms
- Forms NB5094US (06/2008), NB5076US (06/2008) for informational purposes

Company and Contact

Filing Contact Information

Debbie Tom, Contract Analyst	Debbie_Tom@jhancock.com
200 Bloor St E	416-852-2035 [Phone]
Toronto, ON M4W 1E5	416-926-3121 [FAX]

Filing Company Information

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

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Filing Fees

Fee Required? Yes
Fee Amount: \$80.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company (U.S.A.)	\$80.00	11/25/2009	32311218

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/01/2009	12/01/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
State Status	Note To Filer	Linda Bird	11/30/2009	11/30/2009
State Status	Note To Reviewer	Debbie Tom	11/27/2009	11/27/2009

SERFF Tracking Number: MANU-126399004 State: Arkansas
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Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Supporting Document	Forms NB5094US (06/2008), NB5076US (06/2008) for informational purposes		Yes
Supporting Document	Copy of highlighted form (marked with changes)		Yes
Form	Application for Life Insurance		Yes
Form	Application for Term Life Insurance – Single Life		Yes
Form	Important Notice: Replacement of Life Insurance or Annuities (Model Regulation)		Yes
Form	LifeCare Application for Life Insurance		Yes

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Note To Filer

Created By:

Linda Bird on 11/30/2009 09:41 AM

Last Edited By:

Linda Bird

Submitted On:

12/01/2009 08:55 AM

Subject:

State Status

Comments:

This filing has not been reviewed yet, please disregard this error. Correction will be made on the state status. Thanks

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Note To Reviewer

Created By:

Debbie Tom on 11/27/2009 09:30 AM

Last Edited By:

Linda Bird

Submitted On:

12/01/2009 08:55 AM

Subject:

State Status

Comments:

Hi there,

I noticed that the State Status has been changed to Disapproved-Closed. Please advise the reason for disapproval.

Thank you.

Debbie Tom
416-852-2035

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	NB5000AR (11/2009)	Application/ Enrollment Form Application for Life Insurance	Revised	Replaced Form #: NB5000US (12/2007) Previous Filing #: MANU-125381606	45.000	NB5000AR.pdf
	NB5092AR (11/2009)	Application/ Enrollment Form Application for Term Life Insurance – Single Life	Revised	Replaced Form #: NB5092US(04/2007) Previous Filing #: MANU-125158915	43.000	NB5092AR.pdf
	NB5011US (12/2007)	Application/ Enrollment Form Important Notice: Replacement of Life Insurance or Annuities (Model Regulation)	Revised	Replaced Form #: NB5017US (12/2007) Previous Filing #: MANU-125598673	48.000	NB5011US.pdf
	NB5120AR (11/2009)	Application/ Enrollment Form LifeCare Application for Life Insurance	Revised	Replaced Form #: NB5120US (07/2009) Previous Filing #: MANU-126275171	42.000	NB5120AR.pdf



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

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

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

PROPOSED LIFE INSURED(S) LIFE ONE

1. a) Name JOHN M. DOE
First Middle Last

b) Date of Birth OCT 04 1967 c) Sex M F
month day year

d) Place of Birth ANYTOWN USA
State Country

e) Citizenship U.S. Other

f) Social Security Number (SSN), if applicable 1 2 3 4 5 6 7 8 9

g) Driver's License No. 1234567890 State AS

h) Primary Residence 1999 MARCH STREET
Address - Street No. & Name Apt. No.
ANYTOWN, ANystate 12345
City State Zip Code

i) Years at this Address 5

j) Tel. Nos. 905 123-4567 905 123-4567
Home Business

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.
 Secondary Residence 1999 APRIL STREET
Address - Street No. & Name Apt. No.
ANYTOWN, ANystate 23456
City State Zip Code

l) Years at this Address 5

m) Occupation COMPANY PRESIDENT
ABC COMPANY
Name of Employer

LIFE TWO (Survivorship)

2. a) Name _____
First Middle Last

b) Date of Birth _____ c) Sex M F
month day year

d) Place of Birth _____
State Country

e) Citizenship U.S. Other

f) Social Security Number (SSN), if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____
Address - Street No. & Name Apt. No.

City State Zip Code

i) Years at this Address _____

j) Tel. Nos. _____
Home Business

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.
 Secondary Residence _____
Address - Street No. & Name Apt. No.

City State Zip Code

l) Years at this Address _____

m) Occupation _____
Name of Employer

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

If Trust Owner, complete questions 3. a), d) and e) and Trust Certification PS5101.

3. a) Name _____

b) Date of Birth _____ c) Relationship to Proposed Life Insured(s) _____ d) Social Security/Tax ID Number, if applicable _____
month day year

e) Address _____
Street No. & Name Apt. No. City State Zip Code

4. Multiple Owners
 Type of ownership Joint with right of survivorship Tenants in common

Trust Agreement may be required.

Provide all details as above for other Owner in Special Requests on Page 4.

BENEFICIARY INFORMATION – Subject to change by Owner

List additional beneficiaries in Special Requests on Page 4.

5. a) Name JAMES M. DOE Primary SON 100 %
First Middle Last Relationship to Proposed Life Insured(s) Percentage

b) Name _____ Primary _____ %
First Middle Last Relationship to Proposed Life Insured(s) Percentage
 Secondary _____ %
Relationship to Proposed Life Insured(s) Percentage

EXISTING AND PENDING INSURANCE

If more space is required attach additional page that has been signed and dated by Owner if necessary.

6. a) Provide information for each policy in force on the Proposed Life Insured(s) with all companies, including any policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity. **NOT APPLICABLE**

Proposed Life Insured	Company	Insurance		Issue Date			To Remain in Force?		Amount Including Riders
		Personal	Business	month	day	year	Yes	No	
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

- b) Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One No Yes – give details _____

Life Two No Yes – give details _____

- c) Including this application, total insurance currently applied for with all companies (**not including informal inquiries**). Provide name of Life Insurance Company and amount applied for.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
JOHN HANCOCK	\$ 100,000		\$
	\$		\$
	\$		\$

- d) Of the total amount applied for in c) above including this application, what is the maximum that you will accept?

Life One	Life Two
\$ 100,000	\$

JUVENILE INSURANCE

Complete e) & f) if juvenile insurance is applied for.

- e) Are all siblings equally insured? Yes No

- f) Amount of life insurance currently in force or pending on parent(s)/guardian(s)? \$ _____

If none, provide reason. _____

REPLACEMENTS – OWNER

7. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)?
- Yes No If 'Yes', please complete the **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011**.

FINANCIAL QUESTIONS

Copies of financial statements, estate analyses, contractual agreements may be required.

8. Is there, or are you considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in this application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application?

No Yes - If 'Yes', provide details _____

9. Have you been offered any money or other considerations by any person or entity in connection with this application?

No Yes - If 'Yes', provide details _____

- 10.a) What is the source of the premiums for the policy(ies) currently applied for? **SELF FUNDED**

- b) Will the Owner be receiving funding for the premiums from an individual and/or entity other than the Proposed Life Insured(s) or the Proposed Life Insured's employer?

Yes - If 'Yes', answer question 11 below.

No - If 'No', proceed to question 12.

- 11.a) Will the premiums be financed through a loan?

No - If 'No' describe the funding arrangement _____

Yes - If 'Yes' provide the loan details in question 11 b), c), d), e) and f) below.

- b) What is the annual interest rate? _____ %

- c) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?

No Yes - If 'Yes', provide details _____

FINANCIAL QUESTIONS continued

Copies of financial statements, estate analyses, contractual agreements may be required.

11. d) What is the duration of the loan? _____
 e) Who is the lender? _____
 f) What amount and type of collateral is required to secure the loan? \$ _____
 Amount Type of Collateral
12. a) What is the purpose of this insurance? _____
 (e.g. estate conservation, buy-sell, keyperson)
- | | Life One | Life Two |
|---|----------|----------|
| b) Gross annual earned income (salary, commissions, bonuses, etc.) | \$ _____ | \$ _____ |
| c) Gross annual unearned income (dividends, interest, gross real estate income, etc.) | \$ _____ | \$ _____ |
- d) Household net worth (combined) \$ _____
 e) In the last 5 years, has the Proposed Life Insured(s) or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? Life One No Yes - give details _____
 Life Two No Yes - give details _____

BUSINESS FINANCIAL QUESTIONS

- | | Current Year | Previous Year | | |
|---|--------------------------------------|---------------|----------|--|
| Complete for ALL Business Insurance.

Copies of financial statements may be required. | 13. a) Assets | \$ _____ | \$ _____ | f) How was the amount applied for determined? _____ |
| | b) Liabilities | \$ _____ | \$ _____ | g) What percentage of the business is owned by the Proposed Life Insured(s)? _____ % |
| | c) Gross Sales | \$ _____ | \$ _____ | h) Are other partners/owners/executives insured or applying for life insurance with any company? <input type="checkbox"/> No <input type="checkbox"/> Yes - give details _____ |
| | d) Net Income | \$ _____ | \$ _____ | |
| | e) Fair Market Value of the business | \$ _____ | \$ _____ | |

LIFESTYLE QUESTIONS

Please provide details in No. 18 for 'Yes' answers to Lifestyle Questions.

14. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?
15. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years?
 If 'Yes', please complete **Aviation Questionnaire NB5009**.
- b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years?
 If 'Yes', please complete **Avocation Questionnaire NB5010**.
16. a) Have you been cited for 2 or more moving violations within the last 2 years?
 b) Have you been cited for driving while intoxicated or while otherwise impaired?
17. In the last 10 years, have you been convicted of a felony offense?

Life One	Life Two
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

18.	Question No.	Life One	Question No.	Life Two

PRIMARY PHYSICIAN – PROPOSED LIFE INSURED(S)

LIFE ONE

19. Provide name and address of primary physician.

Name ARTHUR H SMITH
 First Middle Last

Address 123 MAIN STREET
 Street No. & Name Suite No.

ANYTOWN, ANYSTATE 12347
 City State Zip Code

LIFE TWO

20. Provide name and address of primary physician.

Name _____
 First Middle Last

Address _____
 Street No. & Name Suite No.

 City State Zip Code

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE

- 21.a) Date of last visit to ANY doctor/physician JAN 15 2007
month day year
- b) Reason for visit ANNUAL CHECK-UP
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed NONE
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

LIFE TWO

- 22.a) Date of last visit to ANY doctor/physician _____
month day year
- b) Reason for visit _____
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed _____
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

23. Has a **John Hancock Medical Exam NB5033** been completed or will it be completed?
 If 'No', complete question 24 and Medical Certification below.
24. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 If 'Yes', give details below.

Life One	Life Two
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Life One:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes	_____ pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Life Two:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes	_____ pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

MEDICAL CERTIFICATION

Complete this section when submitting a medical examination form of another company in lieu of John Hancock Medical Exam NB5033.

25.

	Name of Proposed Life Insured	Name of Insurance Company	Date of Examination		
			month	day	year
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

- a) To the best of your knowledge and belief, is the information in the examination true and complete as of the date this application is signed?

Life One	Life Two
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

COVERAGE APPLIED FOR

26. Complete the applicable **Coverage Details Form NB5007** (Universal Life), **NB5008** (Variable Life) or **NB5013** (Term & Traditional Life) for details of the policy being applied for, including Supplementary Benefits and other benefit options.

SPECIAL REQUESTS – Attach additional page if more space is required.

TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION

Money may NOT be collected and the **Temporary Life Insurance Receipt and Agreement NB5004** may NOT be issued if:

1. questions 28 and 29 are answered Yes or left blank; or
2. the Proposed Life Insured(s) is under age 20 or over age 70; or
3. the amount applied for is more than \$10,000,000 (single life) or \$15,000,000 (survivorship).

27. Is coverage being applied for under the Temporary Life Insurance Agreement? Yes No

If 'Yes', answer questions 28 and 29.

28. Within the last 24 months, has the Proposed Life Insured(s) under this application:

- a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer?
- b) consulted with or scheduled a consultation with a medical professional for any symptoms or medical concerns?
- c) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?
- d) been declined for life insurance?

Life One	Life Two
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

29. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?

PRE-AUTHORIZED PAYMENT PLAN

Attach voided
sample check.

30. Request for Pre-Authorized Payment Plan

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		month	day	year	Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

- a) Such checks (which may include withdrawals made electronically) shall be drawn monthly to pay premiums falling due on the designated policies.
- b) While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
- c) The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
- d) The first premium paid must be submitted by check.

DECLARATIONS

The Proposed Life Insured(s) and Owner (or Parent or Guardian) declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I/we understand and agree that:

1. The statements and the answers in this application, which include coverage details and any supplemental form relating to health, aviation practices or lifestyle of the Proposed Life Insured(s), will become part of the insurance policy issued as a result of this application.
2. a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that since the date of the application there has been no deterioration in the insurability of the Proposed Life Insured(s), no changes in the lifestyle of the Proposed Life Insured(s), no change in the financial circumstances of the Owner, and nothing has occurred that would require a change to any statement or answer in any part of this application in order to make the statement or answer true and complete as of the date the policy becomes effective. If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage, the policy will not be put into effect, and ii) if there is TIA coverage and the TIA has not ended, the policy will be put into effect but only to the limit of the TIA coverage amount.
 - b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurer:
 - a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
4. If coverage under a TIA is applied for, I/we have received, read and understand the terms and conditions of the **Temporary Life Insurance Receipt and Agreement NB5004**.

OWNER/TAXPAYER CERTIFICATION QUESTIONS

U.S. Person(s) (including U.S. Resident/Alien(s))

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

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

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

Non U.S. Person(s) and Non Resident Alien(s)

I am providing IRS Form W-8BEN. Yes No

AUTHORIZATION TO OBTAIN INFORMATION

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

1. The Company to obtain an investigative consumer report on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me/us or any minor child/children who is/are to be insured.

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

I/We further authorize The Company to disclose such information and any information developed during its evaluation of this application to:

(a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me/us; (d) me/us; (e) my/our insurance agent, when that agent is seeking insurance coverage through The Company on my/our behalf; (f) any medical professional designated by me/us; or (g) any person or entity entitled to receive such information by law or as I/we may further consent.

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

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

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

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

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

If Proposed Life Insured(s) is under age 15 Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year
Signature of Owner (Signing Officer please provide title or corporate seal)			Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 15)		
X			X		
			Signature of Proposed Life Insured Two if other than Owner		
			X		
Agent signature	Signature of Agent/Registered Representative			Signed this	Day of Year
X					



Application for Term Life Insurance - Single Life

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

(hereinafter referred to as The Company)

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

• Print and use black ink. Any changes must be initialed by the Proposed Life Insured and Owner.

Policy No. (for Internal Use Only)

Proposed Life Insured

1. a) Name

First	Middle	Last
JOHN	M.	DOE

 b) Date of Birth

month	day	year
OCT	04	1967

c) Sex M F d) Place of Birth

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

 e) Citizenship U.S. Other

f) Social Security/Tax ID Number

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

 g) Driver's Information

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

h) Primary Residence

Address - Street No. & Name, Apt No., City, State, Zip code		Years at this Address
1999 MARCH STREET ANYTOWN, ANYSTATE 12345		5

i) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.

Secondary Residence Address - Street No. & Name, Apt No., City, State, Zip code		Years at this Address

j) Tel Nos.

Home	(905) 123-4567
Business	(905) 123-8976

 k) Employment Information

Occupation	COMPANY PRESIDENT
Name of Employer	ABC COMPANY

Owner - Complete information only if Owner is other than Proposed Life Insured.

If Trust Owner, complete questions 2 a), c) and d) and Trust Certification PS5101.

2. a) Name

Name

 b) Relationship to Proposed Life Insured

Relationship to Proposed Life Insured

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

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

 d) Social Security/Tax ID Number

Social Security/Tax ID Number

Premium Notices and Correspondence

3. a) Send Premium Notices to: (Select one) Owner Proposed Life Insured Other:

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

b) Send Policy Correspondence to: (Select one) Owner Proposed Life Insured Same as 3. a) above Other:

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

Beneficiary Information - Subject to change by Owner - List additional beneficiaries in Special Requests, page 3, question 18.

4.

First	Middle	Last	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary	Relationship to Proposed Life Insured	Percentage
JANE	M.	DOE		SPOUSE	100 %

First	Middle	Last	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Relationship to Proposed Life Insured	Percentage
					%

Policy Details

5. a) Amount applied for

\$ 250,000

b) John Hancock Term

Level Premium	<input checked="" type="checkbox"/> Term 10	<input type="checkbox"/> Term 15	<input type="checkbox"/> Term 20	<input type="checkbox"/> Other -
---------------	---	----------------------------------	----------------------------------	----------------------------------

c) Additional Benefits Accelerated Death Benefit Total Disability Waiver Conversion Extension Rider (Term 15 and Term 20 only)

d) Premium Frequency Annual Semi-Annual Quarterly List Billed Pre-Authorized Payment Plan - Complete "Request for Pre-Authorized Payment Plan" - page 3

Existing and Pending Insurance - Proposed Life Insured

6. a) Total insurance in force on the Proposed Life Insured, including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. \$ 0
- b) Including this application, total insurance currently applied for with all companies via **Formal Applications** \$ 250,000
- c) Of the above applied for amount in 6 b), what is the maximum amount that you will accept? \$ 250,000
- d) Have you ever had an application for life or health insurance declined, postponed, rated substandard or offered with a reduced face amount?
 No Yes - give details _____
- e) Provide information for each policy in force on the Proposed Life Insured, including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. (Attach additional page if necessary.) **NOT APPLICABLE**

Company	Insurance			Issue Date			To Remain In Force?		Face Amount
	Group	Personal	Business	month	day	year	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

Existing Insurance - Owner(s) Replacement(s)

7. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)? Yes No If **Yes**, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011.

Financial Questions - Please submit copies of financial statements, estate analysis, contractual agreements, etc.

8. a) What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson) INCOME REPLACEMENT
- b) Gross annual earned income (salary, commissions, bonuses, etc.) \$ 100,000
- c) Gross annual unearned income (dividends, interest, net real estate income, etc.) \$ 0
- d) Household net worth \$ 1,000,000
- e) In the last 5 years, has the Proposed Life Insured or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? No Yes - give details _____
9. a) What is the source of the funding for the policy(ies) currently applied for? SELF FUNDED
- b) If the premiums are to be funded through a loan, please provide details of the financing arrangement.
 N/A Details of the arrangement _____

Business Insurance - Complete for ALL Business Insurance

- | | Current Year | Previous Year |
|--------------------------------------|--------------|---------------|
| 10. a) Assets | \$ | \$ |
| b) Liabilities | \$ | \$ |
| c) Gross Sales | \$ | \$ |
| d) Net Income after taxes | \$ | \$ |
| e) Fair Market Value of the business | \$ | \$ |
- f) How was the amount applied for determined? _____
- g) What percentage of the business is owned by Proposed Life Insured? _____ %
- h) Are other partners/owners/executives insured or applying for life insurance with any company? Yes No
Give details _____

Lifestyle Questions - Please provide details in No 15 for "Yes" answers.

11. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years? Yes No
12. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years? If **Yes**, please complete Aviation Questionnaire NB5009. Yes No
- b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years? If **Yes**, please complete Avocation Questionnaire NB5010. Yes No
13. a) Have you committed 2 or more moving violations within the last 2 years? Yes No
- b) Have you been convicted of driving while intoxicated or while otherwise impaired? Yes No
14. In the last 10 years, have you been convicted of a felony offense? Yes No

15. Question No.	Details for any "Yes" answers to Lifestyle Questions

Additional Questions

16. Has a John Hancock Medical Exam NB5033 been completed or will it be completed? Yes No If **No**, complete Health Questionnaire NB5002 and question 17 below.
17. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 No Yes - give details below

Product	Frequency pack(s) / day	Current	Past	Date Last Used		
				month	day	year
Cigarettes	_____ / day	<input type="checkbox"/>	<input type="checkbox"/>			
Cigars	_____ x / day	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	_____ x / day	<input type="checkbox"/>	<input type="checkbox"/>			

Special Requests

18.

Temporary Life Insurance Agreement Application

19. Is coverage being applied for under the Temporary Life Insurance Agreement? Yes No
 If **Yes**, answer questions 20 and 21.

Money may **NOT** be collected and the Temporary Life insurance Agreement and Receipt NB5004 may **NOT** be issued if:

1. questions 20 and/or 21 are answered **Yes** or left blank; or
2. the Proposed Life Insured is under age 20 or over age 70; or
3. the amount applied for is more than \$10,000,000.

Has the Proposed Life Insured:

20. a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer within the last 24 months? Yes No
- b) had any symptoms or medical concerns for which a doctor has not been consulted, or any consultation, testing or investigation recommended by a doctor which has not yet been completed? Yes No
- c) been declined for life insurance within the past two years? Yes No
21. Does the Proposed Life Insured reside outside the United States more than 6 months per year? Yes No

Request for Pre-Authorized Payment Plan

A voided sample check showing banking particulars must accompany this application.

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		month	day	year	Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

1. Such checks (which may include withdrawals made electronically) shall be drawn in the month to pay premiums falling due in such month on the designated policies.
2. While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
3. The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
4. The first premium paid must be submitted by check.

Declarations and Authorizations

DECLARATIONS

The Proposed Life Insured and Owner(s) declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I/we understand and agree that:

1. The statements and answers in this application, which include any supplemental form relating to the health, aviation or lifestyle of the Proposed Life Insured, will become part of the insurance policy issued as a result of this application.
2. a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that there has been no deterioration in the insurability of the Proposed Life Insured since the date of the application. If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage in effect at the time the policy is issued, the policy will not be put into effect; and ii) if there is TIA coverage and the TIA is in effect, the policy will be put into effect but only to the limit of the TIA coverage amount.
2. b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurer: a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
4. If the coverage under a Temporary Life Insurance Agreement is applied for, I/we have received, read and understand the terms and conditions of the Temporary Life Insurance Agreement and Receipt NB5004.

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

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

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

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

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

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

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

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

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

Signatures - Please read all of the above Declarations and Authorizations before signing this form.

Signed at City, State	This	Day of	Year
Signature of Agent (as Witness)		Signature of Proposed Life Insured	
X		X	

Signed at City, State	This	Day of	Year
Signature of Agent (as Witness)		Signature of Owner, if other than a Proposed Life Insured (Signing Officer please provide title or corporate seal)	
X		X	
		Signature of Owner, if other than a Proposed Life Insured (Signing Officer please provide title or corporate seal)	
		X	



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

IMPORTANT NOTICE:
Replacement of Life Insurance or Annuities (Model Regulation)
John Hancock Life Insurance Company (U.S.A.)
 (hereinafter referred to as The Company)

This Important Notice must be read to the Owner. It must be signed by the Owner and the Agent/Registered Representative and a copy of the signed form left with the Owner. This Notice must be submitted with the Application for Life Insurance.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name **JOHN M. DOE**
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

3. I do not want this notice read aloud to me. _____ (Owner must initial only if this instruction applies.)
Initials

REPLACEMENT

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases, this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A **REPLACEMENT** occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A **FINANCED PURCHASE** occurs when the purchase of a new policy involves the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from, values of an existing policy to pay all or part of any premium due on a new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the following pages.

- 4. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer or otherwise terminating your existing policy or contract? No Yes - give details below
- 5. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? No Yes - give details below

If you answered 'Yes' to either of the above questions, complete the following information for each existing policy or contract you are contemplating replacing.

Complete for all applicable policies to be replaced.

INSURANCE COMPANY _____ **POLICY NUMBER** _____

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) Replacement Financing
- g) 1035 Exchange? Yes No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) Replacement Financing
- g) 1035 Exchange? Yes No

REPLACEMENT continued

Continue list on another page if you have more than 3 existing policies.

INSURANCE COMPANY _____

POLICY NUMBER _____

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) Replacement Financing
- g) 1035 Exchange? Yes No

Make sure you know the facts. Contact your existing company or its agent/registered representative for information about the old policy. (If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent/registered representative in the sales presentation. Be sure that you are making an informed decision.

AGENT'S STATEMENT

6. The existing policy or contract is being replaced because _____

Note: Confirmation of Marketing Materials, NB5012 must also be completed.

REMINDER TO AGENT/REGISTERED REPRESENTATIVE: John Hancock's policy concerning replacement appears in the "Agent's Code of Conduct" and states: The "Replacement" of existing policies should only occur when it is demonstratively in the best interest of the client and in compliance with all applicable state and Company requirements. You must disclose all of the advantages and disadvantages of any replacement. The client must fully understand the financial consequences of this action and, where required by regulation, Company policy or industry practice, consent to it in writing. You must indicate on every application for new coverage whenever a replacement is involved in that sale.

REPLACEMENT ISSUES

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the cost and benefits of your existing policy and the proposed policy. One way to do this is to ask the company or agent that sold you your existing policy to provide you with information concerning your existing policy. This may include an illustration of how your existing policy is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies. You should discuss the following with your agent/registered representative to determine whether replacement or financing your purchase makes sense.

PREMIUMS

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy?
On the old policy?

POLICY VALUES

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid. You will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY

- If your health has changed since you bought your old policy, the new one could cost you more, or your application could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (Ask your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

COMPARISON OF EXISTING AND PROPOSED POLICY

ALL questions must be answered.

7. In comparison with the existing policy, indicate the appropriate answer to the following questions. On the new policy:

- a) Is the guaranteed death benefit higher? Yes No Not applicable
- b) Are the guaranteed cash values higher? Yes No Not applicable
- c) Is the guaranteed interest rate higher? Yes No Not applicable
- d) Is the face amount higher? Yes No Not applicable
- e) Is the annual premium lower? Yes No Not applicable
- f) Is the loan interest rate lower? Yes No Not applicable
- g) Is the underwriting classification more favorable? Yes No Not applicable
- h) Will any ownership problems be resolved? Yes No Not applicable
- i) Will any beneficiary problems be resolved? Yes No Not applicable

You have a "free-look" period within which to examine the proposed policy. If you are not satisfied, you can return it for a full refund within the period stated in the new policy.

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or you may only be able to purchase it at substantially higher rates.

SIGNATURES

I certify that the information and responses given to the questions in this form are, to the best of my knowledge, accurate.

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Name of Owner (Please print)

Signature of Owner

X

Name of Agent/Registered Representative as Witness (Please print)

Signature of Agent/Registered Representative as Witness

X

ADDITIONAL OWNERS SIGNATURES IF MULTIPLE OWNERS

If additional Owner signatures required please attach additional page including Owner name, date and signature.

Name of Owner (Please print)

Signature of Owner

X

month | day | year

Name of Owner (Please print)

Signature of Owner

X

month | day | year



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

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

Any changes must be initiated by the Proposed Life Insured and Owner.

PROPOSED LIFE INSURED

1. a) Name **JOHN** **M.** **DOE** b) Sex Male Female
First Middle Last

c) Date of Birth **OCT** **04** **1967** d) Social Security Number (SSN) **1 2 3 4 5 6 7 8 9**
month day year

e) Telephone Numbers **905 123-4567** **905 123-4567**
Home Business

f) Primary Residence **1999 MARCH STREET** g) If you live at your primary residence less than 6 months, provide address for secondary residence.
Address - Street No. & Name Apt. No.
ANYTOWN, ANYSTATE 12345 Secondary Residence **1999 APRIL STREET**
City State Zip Code Address - Street No. & Name Apt. No.
ANYTOWN, ANYSTATE 23456
City State Zip Code

h) Employment Information **COMPANY PRESIDENT** **ABC COMPANY** i) Are you actively working?
Occupation Employer Name Yes No

j) Send correspondence to primary address? Yes No If 'No', please provide address below
Address - Street No. & Name Apt. No. City State Zip Code

OWNER – Complete only if Owner is other than Proposed Life Insured

2. a) Name _____ b) Date of Birth/Trust Date _____
month day year

c) Relationship to Proposed Life Insured _____ d) Social Security/Tax ID Number, if applicable _____

e) Address _____
Street No. & Name Apt. No. City State Zip Code

f) Multiple Owners - Type of ownership Joint with right of survivorship Tenants in common

BENEFICIARY INFORMATION

3. a) Beneficiary **JAMES** **M.** **DOE** Primary **SON** **100** %
First Middle Last Relationship to Proposed Life Insured Percentage

b) Beneficiary _____ Primary _____ %
First Middle Last Secondary Relationship to Proposed Life Insured Percentage

EXISTING AND PENDING INSURANCE

4. a) Does the Owner have any existing life insurance and/or annuity policies including any policies in the process of being surrendered or lapsed?
 Yes No If 'Yes', please complete the state appropriate replacement forms.

b) Provide information for each policy in force on the Proposed Life Insured with all companies. Not applicable

Company	Issue Date			To Remain in Force?		Amount
	month	day	year	Yes	No	
				<input type="checkbox"/>	<input type="checkbox"/>	\$
				<input type="checkbox"/>	<input type="checkbox"/>	\$
				<input type="checkbox"/>	<input type="checkbox"/>	\$

c) Have you ever had an application for life or long term care insurance declined, postponed, rated substandard or offered with a reduced amount?
 No Yes – If 'Yes', give details _____

SPECIAL REQUESTS - Attach additional page if more space is required.

5.

POLICY DETAILS

- 6. a) Face Amount \$ **500,000** _____ b) Single Premium \$ **100,000** _____
- c) Acceleration Benefit Rider Yes No
 Continuation of Acceleration Benefit Rider Yes No
 Total Acceleration Benefit Period
 2 Years 3 Years 4 Years 5 Years 6 Years 7 Years
 Years 4, 5, 6 or 7 are only available when the Continuation of Acceleration Benefit Rider is selected.
- d) Optional Riders Accelerated Death Benefit (for terminal illness)
 Other _____

FINANCIAL QUESTIONS

- 7. a) Gross annual income (salary, commissions, bonuses, etc.) \$ **500,000** _____
 b) Net worth \$ **5,000,000** _____
- 8. What is the source of the premiums for this policy? **SELF FUNDED** _____

LIFESTYLE QUESTIONS

- 9. Have you smoked cigarettes during the past 12 months? Yes No
 If 'Yes', how many in a week? _____
- 10. Do you engage in regular exercise? Yes No
- 11. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? Yes No
- 12. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes in the last 2 years? Yes No
 b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, boxing, or any other hazardous activities in the last 2 years? Yes No
- 13. a) Have you been cited for one or more driving violations, other than parking tickets, within the last 3 years? Yes No
 b) Have you been cited for driving while intoxicated or while otherwise impaired? Yes No
- 14. In the past 10 years, have you been convicted of a felony offense? Yes No

Details for 'Yes' answers to Lifestyle Questions 10 - 14.

Question No.	Question No.	Question No.	Question No.

INFORMATION REGARDING LAST MEDICAL CONSULTATION

16. a) Date of last visit to ANY doctor/physician JAN 15 2009
month day year
- b) Reason for visit ANNUAL CHECK-UP
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed NONE
- e) Name of doctor/physician for above
 Primary doctor/physician
 Other doctor/physician
- | | | |
|-------------------|--------|-----------|
| First | Middle | Last |
| Street No. & Name | | Suite No. |
| City | State | Zip Code |
- f) List of all medications and dosages you are currently taking including prescription and non-prescription drugs.

HEALTH QUESTIONS

17. Have any of your immediate family members (parents, brothers or sisters) prior to age 60:
- a) been diagnosed or died from coronary artery disease, stroke or cancer? Yes No
- b) been diagnosed with polycystic kidney disease or Huntington's chorea? Yes No
18. a) Your Height _____ Your Weight _____
- b) Has your weight changed 10 pounds or more in the past 2 years? Yes No
19. **Within the last 10 years, have you had symptoms of, received medical advice, diagnosis or treatment, or consulted or been treated by a member of the medical profession for any of the following conditions:**
- a) Chest pain, angina, congestive heart failure, coronary artery disease, cardiomyopathy, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, atrial fibrillation, heart valve disease or any other disease or disorder of the heart or arteries? Yes No
- b) Diabetes, elevated blood sugar or glucose intolerance, thyroid, or any other endocrine or gland disease? Yes No
- c) Any nervous, mental illness or emotional disorder, schizophrenia, or received counseling for anxiety, depression, stress, or any other emotional condition? Yes No
- d) Gout, chronic fatigue, fibromyalgia, polymyalgia rheumatica, lupus, neuropathy, or any other skin, nerve or joint disorders? Yes No
- e) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? Yes No
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach, intestines or digestive system? Yes No
- g) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? Yes No
- h) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? Yes No
- i) Disease of the urinary tract, bladder, kidneys, sugar, protein or blood in the urine or any other genitourinary disorders? Yes No
- j) Cancer, leukemia, lymphoma, malignant melanoma, tumors, or cysts of any kind, malignant or benign? Yes No
- k) Any disease of the eye, ear, nose or throat? Yes No
- l) Any other health impairment or medically treated condition? Yes No
20. **Within the last 10 years have you had:**
- a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? Yes No
- b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), whether conducted on an in-patient or out-patient basis? Yes No
21. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

1. The Company to obtain an investigative consumer report on me.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, the MIB, Inc. or any other similar person or organization to give The Company and its reinsurers information about me.

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

I further authorize The Company to disclose such information and any information developed during its evaluation of my application to: (a) its reinsurers; (b) the MIB, Inc.; (c) other insurance companies as designated by me; (d) me; (e) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (f) any medical professional designated by me; or (g) any person or entity entitled to receive such information by law or as I may further consent.

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

This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original. Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

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

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

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

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Signature of Owner

Signature of Proposed Life Insured (if other than Owner)

X

X

Agent signature

Signature of Agent/Registered Representative

Signed this

Day of

Year

X



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

Complete and submit with LifeCare Application for Life Insurance.

PROPOSED LIFE INSURED

1. a) Name JOHN M. DOE
First Middle Last

AGENT QUESTIONS

To be completed by the Agent/Registered Representative.

1. Does the Owner have any existing life insurance and/or annuity policies including any policies in the process of being surrendered or lapsed?
 Yes No If 'Yes', I have presented and read the state appropriate replacement forms to the Owner and have submitted them with the application.
2. a) Did you meet with the client in person? Yes No If 'No', complete 2 b).
 b) Describe how this business was solicited. _____
3. Agent Information

Name of Agent/Entity	Agent Code	Social Security No.	Telephone No.	E-mail Address	% Share
JOHN J. CORCORAN	99999	987654321	905 123-6900		100 %

Name of Broker Dealer (if applicable) _____ **Total must equal 100%**

CERTIFICATION AND SIGNATURE

Agent/Registered Representative for this policy must sign this form.

I declare that I know nothing affecting the insurability of the Proposed Life Insured which is not fully recorded in this application or the application supplement.
 I certify that the Buyer's Guide, Outline of Coverage, Notice of Disclosure, and an Illustration were given to the Owner at time of application and that no sales material other than that approved by The Company was used.

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Signature of Agent/Registered Representative

X _____

SERFF Tracking Number: MANU-126399004 State: Arkansas
 Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 44192
 Company Tracking Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
 Project Name/Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)/NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments:		
Attachment: flesch ar.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application		
Bypass Reason: not applicable		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability		
Comments:		
Attachment: Statement of Variability ar.pdf		

	Item Status:	Status Date:
Satisfied - Item: Forms NB5094US (06/2008), NB5076US (06/2008) for informational purposes		
Comments:		
Attachments: NB5076US.pdf NB5094US.pdf		

	Item Status:	Status
--	---------------------	---------------

SERFF Tracking Number: MANU-126399004 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 44192
Company Tracking Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)
Project Name/Number: NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)/NB5000AR (11/2009)/NB5092AR (11/2009)/NB5120AR (11/2009)/NB5011US (12/2007)

Date:

Satisfied - Item: Copy of highlighted form (marked with changes)

Comments:

Attachments:

NB5000AR_HILITED_112009.pdf

NB5092AR_HILITED_112009.pdf

NB5120AR_HILITED_112009.pdf

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

FLESCH SCORE CERTIFICATION

FOR THE STATE OF ARKANSAS

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

FORM NUMBER	READABILITY SCORE
NB5000AR (11/2009)	45
NB5092AR (11/2009)	43
NB5120AR (11/2009)	42
NB5011US (11/2009)	48

November 25, 2009
Date



Helene Landow, FLMI, ACP
Director, Contracts and Compliance

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

STATEMENT OF VARIABILITY

November 25, 2009

APPLICATION FOR LIFE INSURANCE

FORM NB5000AR (11/2009)

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

APPLICATION FOR TERM LIFE INSURANCE – SINGLE LIFE

FORM NB5092AR (11/2009)

Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current Service Office address will always appear on the form.
Policy Details, #5	Page 1	Amount applied for, Plan Name, Additional Benefits and Premium Frequency all vary based on issue specifications at time of application.

LIFECARE APPLICATION FOR LIFE INSURANCE

FORM NB5120AR (11/2009)

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

IMPORTANT NOTICE: REPLACEMENT LIFE INSURANCE OR ANNUITIES (MODEL REGULATION)

FORM NB5011US (12/2007)

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



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

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

Complete and submit with Application for Life Insurance. Print and use black ink.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

AGENT QUESTIONS

To be completed by the Agent/Registered Representative.

3. a) Total Premium Collected: \$ _____ b) Has a Temporary Life Insurance Agreement been issued? Yes No
4. a) Question No. 8 of the application asks if there is, or if the applicant is considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in the application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of the application. Examples of such an understanding or agreement include, but are not limited to, arrangements where the proposed Owner has or will have an option to sell to a third party the Owner's interest in the policy, or where a third party has or will have an option to buy the proposed Owner's interest in the policy. With this understanding, has Question No. 8 been answered appropriately?
 Yes No - give details _____
- b) Will any policy issued on the life of the Proposed Life Insured(s) as a result of this application, replace a policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity? Yes No
- c) Will the premiums, now or in the future, be funded by a loan or other means from someone other than the Insured or the Insured's employer? No Yes - give details of the funding arrangement. If applicable, describe the name of the lender, interest rate, term of loan, other fees, charges or other consideration to be paid on maturity of loan and required amount and type of collateral. _____

5. Will any entity other than a life insurance company be medically evaluating the Proposed Life Insured(s) to determine life expectancy or to otherwise obtain financing? No Yes - give details _____
6. a) Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)? Yes No If Yes, the Agent/Registered Representative is required to present and read **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011** to the Owner. The completed form must be submitted with Application
- b) If Accident and Sickness or Long Term Care is being replaced, please give the Proposed Life Insured the **Notice for Replacement of Individual Accident and Sickness or Long-term Care Insurance, NB5019**.

c) List any other health insurance policies you have sold to the applicant.

Health policies in force	Health policies sold in the past 5 years and no longer in force

7. a) Did you see each Proposed Life Insured when the application was completed? Yes No - If 'No', answer question 7 b).
b) Please describe how the application was solicited and completed. _____

8. a) Will this policy be owned by the employer of the Proposed Life Insured(s)? Yes No - If 'Yes', answer questions 8 b) & 8 c).
b) The Proposed Life Insured(s) has received written notice, which: (i) indicates that the employer intends to insure the employee's life; (ii) specifies the maximum face amount for which the employee could be insured at the time the policy is issued; and (iii) informs the insured that the employer will be the beneficiary of the policy. Yes No
c) The Proposed Life Insured(s) has provided written consent to being insured and that such coverage may continue after the employment relationship terminates. Yes No

9. Agent Information

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

Name of Broker Dealer (if applicable) _____ **Total must equal 100%**

CERTIFICATION AND SIGNATURE

Agent/
Registered
Representative
for this policy
must sign this
form.

I declare that I have asked the Proposed Life Insured(s) and/or the Owner each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Life Insured(s) which is not fully recorded in this application.

I certify that the state approved Buyer's Guide has been given to the Owner at time of application and that no sales material other than that approved by The Company has been used.

Signed at City State This Day of Year

Signature of Agent/Registered Representative

X



Agent Report - Application for Term Life Insurance

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

(hereinafter referred to as The Company)

Life New Business
197 Clarendon Street
Boston, MA 02116-5010

- Complete and submit with Application for Term Life Insurance.
- Print and use black ink.

Policy No. (for Internal Use Only)

Proposed Life Insured

1. Name First, Middle, Last

Agent Questions - To be completed by the Agent

2. a) Total Premium Collected \$ b) Has a Temporary Life Insurance Agreement been issued? Yes No

3. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)? Yes No If Yes, the Agent is required to present and read IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011 to the Owner. The completed form must be submitted with Application.

4. a) Did you see the Proposed Life Insured when the application was completed? Yes No - If No, please answer question 4. b).

b) Please describe how the application was solicited and completed.

5. a) Will this policy be owned by the employer of the Proposed Life Insured? Yes No - If Yes, please answer questions 5. b) and 5. c).

b) The Proposed Life Insured has received written notice, which: (i) indicates that the employer intends to insure the employee's life; (ii) specifies the maximum face amount for which the employee could be insured at the time the policy is issued; and (iii) informs the insured that the employer will be the beneficiary of the policy. Yes No

c) The Proposed Life Insured has provided written consent to being insured and that such coverage may continue after the employment relationship terminates. Yes No

6. Agent Information - Always complete

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

100%

Certification and Signature

I declare that I have asked the Proposed Life Insured and/or the Owner each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Life Insured which is not fully recorded in this application.

I certify that the state approved Buyer's Guide has been given to the Owner at time of application and that no sales material other than that approved by The Company has been used.

Signature of Agent Signed at City, State This Day of Year



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

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

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

PROPOSED LIFE INSURED(S) LIFE ONE

1. a) Name JOHN M. DOE
First Middle Last

b) Date of Birth OCT 04 1967 c) Sex M F
month day year

d) Place of Birth ANYTOWN USA
State Country

e) Citizenship U.S. Other

f) Social Security Number (SSN), if applicable 1 2 3 4 5 6 7 8 9

g) Driver's License No. 1234567890 State AS

h) Primary Residence 1999 MARCH STREET
Address - Street No. & Name Apt. No.
ANYTOWN, ANystate 12345
City State Zip Code

i) Years at this Address 5

j) Tel. Nos. 905 123-4567 905 123-4567
Home Business

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.
 Secondary Residence 1999 APRIL STREET
Address - Street No. & Name Apt. No.
ANYTOWN, ANystate 23456
City State Zip Code

l) Years at this Address 5

m) Occupation COMPANY PRESIDENT
ABC COMPANY
Name of Employer

LIFE TWO (Survivorship)

2. a) Name _____
First Middle Last

b) Date of Birth _____ c) Sex M F
month day year

d) Place of Birth _____
State Country

e) Citizenship U.S. Other

f) Social Security Number (SSN), if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____
Address - Street No. & Name Apt. No.

City State Zip Code

i) Years at this Address _____

j) Tel. Nos. _____
Home Business

k) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.
 Secondary Residence _____
Address - Street No. & Name Apt. No.

City State Zip Code

l) Years at this Address _____

m) Occupation _____
Name of Employer

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

If Trust Owner, complete questions 3. a), d) and e) and Trust Certification PS5101.

3. a) Name _____

b) Date of Birth _____ c) Relationship to Proposed Life Insured(s) _____ d) Social Security/Tax ID Number, if applicable _____
month day year

e) Address _____
Street No. & Name Apt. No. City State Zip Code

4. Multiple Owners
 Type of ownership Joint with right of survivorship Tenants in common

Trust Agreement may be required.

Provide all details as above for other Owner in Special Requests on Page 4.

BENEFICIARY INFORMATION – Subject to change by Owner

List additional beneficiaries in Special Requests on Page 4.

5. a) Name JAMES M. DOE Primary SON 100 %
First Middle Last Relationship to Proposed Life Insured(s) Percentage

b) Name _____ Primary _____ %
First Middle Last Relationship to Proposed Life Insured(s) Percentage
 Secondary _____ %
Relationship to Proposed Life Insured(s) Percentage

EXISTING AND PENDING INSURANCE

If more space is required attach additional page that has been signed and dated by Owner if necessary.

6. a) Provide information for each policy in force on the Proposed Life Insured(s) with all companies, including any policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity. **NOT APPLICABLE**

Proposed Life Insured	Company	Insurance		Issue Date			To Remain in Force?		Amount Including Riders
		Personal	Business	month	day	year	Yes	No	
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

- b) Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One No Yes – give details _____

Life Two No Yes – give details _____

- c) Including this application, total insurance currently applied for with all companies (**not including informal inquiries**). Provide name of Life Insurance Company and amount applied for.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
JOHN HANCOCK	\$ 100,000		\$
	\$		\$
	\$		\$

- d) Of the total amount applied for in c) above including this application, what is the maximum that you will accept?

Life One	Life Two
\$ 100,000	\$

JUVENILE INSURANCE

Complete e) & f) if juvenile insurance is applied for.

- e) Are all siblings equally insured? Yes No

- f) Amount of life insurance currently in force or pending on parent(s)/guardian(s)? \$ _____

If none, provide reason. _____

REPLACEMENTS – OWNER

7. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)?
 Yes No If 'Yes', please complete the **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011.**

FINANCIAL QUESTIONS

Copies of financial statements, estate analyses, contractual agreements may be required.

8. Is there, or are you considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in this application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application?

No Yes - If 'Yes', provide details _____

9. Have you been offered any money or other considerations by any person or entity in connection with this application?

No Yes - If 'Yes', provide details _____

- 10.a) What is the source of the premiums for the policy(ies) currently applied for? **SELF FUNDED**

- b) Will the Owner be receiving funding for the premiums from an individual and/or entity other than the Proposed Life Insured(s) or the Proposed Life Insured's employer?

Yes - If 'Yes', answer question 11 below.

No - If 'No', proceed to question 12.

- 11.a) Will the premiums be financed through a loan?

No - If 'No' describe the funding arrangement _____

Yes - If 'Yes' provide the loan details in question 11 b), c), d), e) and f) below.

- b) What is the annual interest rate? _____ %

- c) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?

No Yes - If 'Yes', provide details _____

FINANCIAL QUESTIONS continued

Copies of financial statements, estate analyses, contractual agreements may be required.

11. d) What is the duration of the loan? _____
 e) Who is the lender? _____
 f) What amount and type of collateral is required to secure the loan? \$ _____
Amount Type of Collateral
12. a) What is the purpose of this insurance? _____
(e.g. estate conservation, buy-sell, keyperson)
- | | Life One | Life Two |
|---|----------|----------|
| b) Gross annual earned income (salary, commissions, bonuses, etc.) | \$ _____ | \$ _____ |
| c) Gross annual unearned income (dividends, interest, gross real estate income, etc.) | \$ _____ | \$ _____ |
- d) Household net worth (combined) \$ _____
 e) In the last 5 years, has the Proposed Life Insured(s) or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? Life One No Yes - give details _____
 Life Two No Yes - give details _____

BUSINESS FINANCIAL QUESTIONS

Complete for ALL Business Insurance.

Copies of financial statements may be required.

- | | Current Year | Previous Year | |
|--------------------------------------|--------------|---------------|--|
| 13. a) Assets | \$ _____ | \$ _____ | f) How was the amount applied for determined? _____ |
| b) Liabilities | \$ _____ | \$ _____ | g) What percentage of the business is owned by the Proposed Life Insured(s)? _____ % |
| c) Gross Sales | \$ _____ | \$ _____ | h) Are other partners/owners/executives insured or applying for life insurance with any company? <input type="checkbox"/> No <input type="checkbox"/> Yes - give details _____ |
| d) Net Income | \$ _____ | \$ _____ | |
| e) Fair Market Value of the business | \$ _____ | \$ _____ | |

LIFESTYLE QUESTIONS

Please provide details in No. 18 for 'Yes' answers to Lifestyle Questions.

14. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?
15. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years?
 If 'Yes', please complete **Aviation Questionnaire NB5009**.
- b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years?
 If 'Yes', please complete **Avocation Questionnaire NB5010**.
16. a) Have you been cited for 2 or more moving violations within the last 2 years?
 b) Have you been cited for driving while intoxicated or while otherwise impaired?
17. In the last 10 years, have you been convicted of a felony offense?

Life One	Life Two
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

18.	Question No.	Life One	Question No.	Life Two

PRIMARY PHYSICIAN – PROPOSED LIFE INSURED(S)

LIFE ONE

19. Provide name and address of primary physician.

Name ARTHUR H SMITH
First Middle Last

Address 123 MAIN STREET
Street No. & Name Suite No.

ANYTOWN, ANYSTATE 12347
City State Zip Code

LIFE TWO

20. Provide name and address of primary physician.

Name _____
First Middle Last

Address _____
Street No. & Name Suite No.

City State Zip Code

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE

- 21.a) Date of last visit to ANY doctor/physician JAN 15 2007
month day year
- b) Reason for visit ANNUAL CHECK-UP
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed NONE
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

LIFE TWO

- 22.a) Date of last visit to ANY doctor/physician _____
month day year
- b) Reason for visit _____
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed _____
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

23. Has a **John Hancock Medical Exam NB5033** been completed or will it be completed?
 If 'No', complete question 24 and Medical Certification below.
24. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 If 'Yes', give details below.

Life One	Life Two
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Life One:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes	_____ pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Life Two:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes	_____ pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	_____ x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

MEDICAL CERTIFICATION

Complete this section when submitting a medical examination form of another company in lieu of John Hancock Medical Exam NB5033.

25.

	Name of Proposed Life Insured	Name of Insurance Company	Date of Examination		
			month	day	year
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

- a) To the best of your knowledge and belief, is the information in the examination true and complete as of the date this application is signed?

Life One	Life Two
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

COVERAGE APPLIED FOR

26. Complete the applicable **Coverage Details Form NB5007** (Universal Life), **NB5008** (Variable Life) or **NB5013** (Term & Traditional Life) for details of the policy being applied for, including Supplementary Benefits and other benefit options.

SPECIAL REQUESTS – Attach additional page if more space is required.

TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION

Money may NOT be collected and the **Temporary Life Insurance Receipt and Agreement NB5004** may NOT be issued if:

1. questions 28 and 29 are answered Yes or left blank; or
2. the Proposed Life Insured(s) is under age 20 or over age 70; or
3. the amount applied for is more than \$10,000,000 (single life) or \$15,000,000 (survivorship).

27. Is coverage being applied for under the Temporary Life Insurance Agreement? Yes No

If 'Yes', answer questions 28 and 29.

28. Within the last 24 months, has the Proposed Life Insured(s) under this application:

- a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer?
- b) consulted with or scheduled a consultation with a medical professional for any symptoms or medical concerns?
- c) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?
- d) been declined for life insurance?

Life One	Life Two
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

29. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?

PRE-AUTHORIZED PAYMENT PLAN

Attach voided
sample check.

30. Request for Pre-Authorized Payment Plan

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		month	day	year	Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

- a) Such checks (which may include withdrawals made electronically) shall be drawn monthly to pay premiums falling due on the designated policies.
- b) While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
- c) The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
- d) The first premium paid must be submitted by check.

DECLARATIONS

The Proposed Life Insured(s) and Owner (or Parent or Guardian) declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I/we understand and agree that:

1. The statements and the answers in this application, which include coverage details and any supplemental form relating to health, aviation practices or lifestyle of the Proposed Life Insured(s), will become part of the insurance policy issued as a result of this application.
2. a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that since the date of the application there has been no deterioration in the insurability of the Proposed Life Insured(s), no changes in the lifestyle of the Proposed Life Insured(s), no change in the financial circumstances of the Owner, and nothing has occurred that would require a change to any statement or answer in any part of this application in order to make the statement or answer true and complete as of the date the policy becomes effective. If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage, the policy will not be put into effect, and ii) if there is TIA coverage and the TIA has not ended, the policy will be put into effect but only to the limit of the TIA coverage amount.
 - b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurer:
 - a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
4. If coverage under a TIA is applied for, I/we have received, read and understand the terms and conditions of the **Temporary Life Insurance Receipt and Agreement NB5004**.

OWNER/TAXPAYER CERTIFICATION QUESTIONS

U.S. Person(s) (including U.S. Resident/Alien(s))

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

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

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

Non U.S. Person(s) and Non Resident Alien(s)

I am providing IRS Form W-8BEN. Yes No

AUTHORIZATION TO OBTAIN INFORMATION

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

1. The Company to obtain an investigative consumer report on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me/us or any minor child/children who is/are to be insured.

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

I/We further authorize The Company to disclose such information and any information developed during its evaluation of this application to:

(a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me/us; (d) me/us; (e) my/our insurance agent, when that agent is seeking insurance coverage through The Company on my/our behalf; (f) any medical professional designated by me/us; or (g) any person or entity entitled to receive such information by law or as I/we may further consent.

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

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

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

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

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

If Proposed Life Insured(s) is under age 15 Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year
Signature of Owner (Signing Officer please provide title or corporate seal)			Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 15)		
X			X		
			Signature of Proposed Life Insured Two if other than Owner		
			X		
Agent signature	Signature of Agent/Registered Representative			Signed this	Day of Year
X					



Application for Term Life Insurance - Single Life

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

(hereinafter referred to as The Company)

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

• Print and use black ink. Any changes must be initialed by the Proposed Life Insured and Owner.

Policy No. (for Internal Use Only)

Proposed Life Insured

1. a) Name

First	Middle	Last
JOHN	M.	DOE

 b) Date of Birth

month	day	year
OCT	04	1967

c) Sex M F d) Place of Birth

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

 e) Citizenship U.S. Other

f) Social Security/Tax ID Number

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

 g) Driver's Information

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

h) Primary Residence

Address - Street No. & Name, Apt No., City, State, Zip code		Years at this Address
1999 MARCH STREET ANYTOWN, ANYSTATE 12345		5

i) If you live at your primary residence less than 6 months per year, provide the address for your secondary residence.

Secondary Residence Address - Street No. & Name, Apt No., City, State, Zip code		Years at this Address

j) Tel Nos.

Home (905) 123-4567	k) Employment Information	Occupation	COMPANY PRESIDENT
Business (905) 123-8976	Name of Employer	ABC COMPANY	

Owner - Complete information only if Owner is other than Proposed Life Insured.

If Trust Owner, complete questions 2 a), c) and d) and Trust Certification PS5101.

2. a) Name

--

 b) Relationship to Proposed Life Insured

--

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

--

 d) Social Security/Tax ID Number

--	--	--	--	--	--	--	--	--	--

Premium Notices and Correspondence

3. a) Send Premium Notices to: (Select one) Owner Proposed Life Insured Other:

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

b) Send Policy Correspondence to: (Select one) Owner Proposed Life Insured Same as 3. a) above Other:

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

Beneficiary Information - Subject to change by Owner - List additional beneficiaries in Special Requests, page 3, question 18.

4.

First	Middle	Last	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary	Relationship to Proposed Life Insured	Percentage
JANE	M.	DOE		SPOUSE	100 %

First	Middle	Last	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Relationship to Proposed Life Insured	Percentage
					%

Policy Details

5. a) Amount applied for \$ 250,000

b) John Hancock Term

Level Premium	<input checked="" type="checkbox"/> Term 10	<input type="checkbox"/> Term 15	<input type="checkbox"/> Term 20	<input type="checkbox"/> Other -
---------------	---	----------------------------------	----------------------------------	----------------------------------

c) Additional Benefits Accelerated Death Benefit Total Disability Waiver Conversion Extension Rider (Term 15 and Term 20 only)

d) Premium Frequency Annual Semi-Annual Quarterly List Billed Pre-Authorized Payment Plan - Complete "Request for Pre-Authorized Payment Plan" - page 3

Existing and Pending Insurance - Proposed Life Insured

6. a) Total insurance in force on the Proposed Life Insured, including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. \$ 0
- b) Including this application, total insurance currently applied for with all companies via **Formal Applications** \$ 250,000
- c) Of the above applied for amount in 6 b), what is the maximum amount that you will accept? \$ 250,000
- d) Have you ever had an application for life or health insurance declined, postponed, rated substandard or offered with a reduced face amount?
 No Yes - give details
- e) Provide information for each policy in force on the Proposed Life Insured, including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. (Attach additional page if necessary.) **NOT APPLICABLE**

Company	Insurance			Issue Date			To Remain In Force?		Face Amount
	Group	Personal	Business	month	day	year	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

Existing Insurance - Owner(s) Replacement(s)

7. Are there any existing life insurance and/or annuity policies owned by the Owner (including existing policies in the process of being lapsed or surrendered)? Yes No If **Yes**, please complete the IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Model Regulation), NB5011.

Financial Questions - Please submit copies of financial statements, estate analysis, contractual agreements, etc.

8. a) What is the purpose of this insurance? (e.g. income replacement, buy-sell, keyperson) INCOME REPLACEMENT
- b) Gross annual earned income (salary, commissions, bonuses, etc.) \$ 100,000
- c) Gross annual unearned income (dividends, interest, net real estate income, etc.) \$ 0
- d) Household net worth \$ 1,000,000
- e) In the last 5 years, has the Proposed Life Insured or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? No Yes - give details
9. a) What is the source of the funding for the policy(ies) currently applied for? SELF FUNDED
- b) If the premiums are to be funded through a loan, please provide details of the financing arrangement.
 N/A Details of the arrangement

Business Insurance - Complete for ALL Business Insurance

	Current Year	Previous Year	
10. a) Assets	\$	\$	f) How was the amount applied for determined?
b) Liabilities	\$	\$	
c) Gross Sales	\$	\$	g) What percentage of the business is owned by Proposed Life Insured? %
d) Net Income after taxes	\$	\$	h) Are other partners/owners/executives insured or applying for life insurance with any company? <input type="checkbox"/> Yes <input type="checkbox"/> No
e) Fair Market Value of the business	\$	\$	Give details

Lifestyle Questions - Please provide details in No 15 for "Yes" answers.

11. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years? Yes No
12. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years? If **Yes**, please complete Aviation Questionnaire NB5009. Yes No
- b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years? If **Yes**, please complete Avocation Questionnaire NB5010. Yes No
13. a) Have you committed 2 or more moving violations within the last 2 years? Yes No
- b) Have you been convicted of driving while intoxicated or while otherwise impaired? Yes No
14. In the last 10 years, have you been convicted of a felony offense? Yes No

15. Question No.	Details for any "Yes" answers to Lifestyle Questions

Additional Questions

16. Has a John Hancock Medical Exam NB5033 been completed or will it be completed? Yes No **If No, complete Health Questionnaire NB5002 and question 17 below.**
17. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 No Yes - give details below

Product	Frequency pack(s) / day	Current	Past	Date Last Used		
				month	day	year
Cigarettes	_____ / day	<input type="checkbox"/>	<input type="checkbox"/>			
Cigars	_____ x / day	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	_____ x / day	<input type="checkbox"/>	<input type="checkbox"/>			

Special Requests

18.

Temporary Life Insurance Agreement Application

19. Is coverage being applied for under the Temporary Life Insurance Agreement? Yes No
If Yes, answer questions 20 and 21.

Money may **NOT** be collected and the Temporary Life insurance Agreement and Receipt NB5004 may **NOT** be issued if:

1. questions 20 and/or 21 are answered **Yes** or left blank; or
2. the Proposed Life Insured is under age 20 or over age 70; or
3. the amount applied for is more than \$10,000,000.

Has the Proposed Life Insured:

20. a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer within the last 24 months? Yes No
- b) had any symptoms or medical concerns for which a doctor has not been consulted, or any consultation, testing or investigation recommended by a doctor which has not yet been completed? Yes No
- c) been declined for life insurance within the past two years? Yes No
21. Does the Proposed Life Insured reside outside the United States more than 6 months per year? Yes No

Request for Pre-Authorized Payment Plan

A voided sample check showing banking particulars must accompany this application.

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		month	day	year	Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

1. Such checks (which may include withdrawals made electronically) shall be drawn in the month to pay premiums falling due in such month on the designated policies.
2. While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
3. The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
4. The first premium paid must be submitted by check.

Declarations and Authorizations

DECLARATIONS

The Proposed Life Insured and Owner(s) declare that the statements and answers in this application and any form that is made part of this application are complete and true.

In addition, I/we understand and agree that:

1. The statements and answers in this application, which include any supplemental form relating to the health, aviation or lifestyle of the Proposed Life Insured, will become part of the insurance policy issued as a result of this application.
2. a) Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that there has been no deterioration in the insurability of the Proposed Life Insured since the date of the application. If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage in effect at the time the policy is issued, the policy will not be put into effect; and ii) if there is TIA coverage and the TIA is in effect, the policy will be put into effect but only to the limit of the TIA coverage amount.
2. b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurer: a) files an application for insurance or statement of claim containing any materially false information, or b) conceals for the purpose of misleading any insurer, information concerning any material fact thereto, may be committing a fraudulent insurance act.
4. If the coverage under a Temporary Life Insurance Agreement is applied for, I/we have received, read and understand the terms and conditions of the Temporary Life Insurance Agreement and Receipt NB5004.

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

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

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

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

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

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

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

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

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

Signatures - Please read all of the above Declarations and Authorizations before signing this form.

Signed at City, State	This	Day of	Year
Signature of Agent (as Witness) X		Signature of Proposed Life Insured X	

Signed at City, State	This	Day of	Year
Signature of Agent (as Witness) X		Signature of Owner, if other than a Proposed Life Insured (Signing Officer please provide title or corporate seal) X	
		Signature of Owner, if other than a Proposed Life Insured (Signing Officer please provide title or corporate seal) X	



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

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

Any changes must be initialed by the Proposed Life Insured and Owner.

PROPOSED LIFE INSURED

1. a) Name **JOHN** **M.** **DOE** b) Sex Male Female
First Middle Last

c) Date of Birth **OCT** **04** **1967** d) Social Security Number (SSN) **1 2 3 4 5 6 7 8 9**
month day year

e) Telephone Numbers **905 123-4567** **905 123-4567**
Home Business

f) Primary Residence **1999 MARCH STREET** g) If you live at your primary residence less than 6 months, provide address for secondary residence.
Address - Street No. & Name Apt. No.
ANYTOWN, ANystate 12345 Secondary Residence **1999 APRIL STREET**
City State Zip Code City State Zip Code

h) Employment Information **COMPANY PRESIDENT** **ABC COMPANY** i) Are you actively working?
Occupation Employer Name Yes No

j) Send correspondence to primary address? Yes No If 'No', please provide address below
Address - Street No. & Name Apt. No. City State Zip Code

OWNER – Complete only if Owner is other than Proposed Life Insured

2. a) Name _____ b) Date of Birth/Trust Date _____
month day year

c) Relationship to Proposed Life Insured _____ d) Social Security/Tax ID Number, if applicable _____

e) Address _____
Street No. & Name Apt. No. City State Zip Code

f) Multiple Owners - Type of ownership Joint with right of survivorship Tenants in common

BENEFICIARY INFORMATION

3. a) Beneficiary **JAMES** **M.** **DOE** Primary **SON** **100** %
First Middle Last Relationship to Proposed Life Insured Percentage

b) Beneficiary _____ Primary _____ %
First Middle Last Relationship to Proposed Life Insured Percentage
 Secondary

EXISTING AND PENDING INSURANCE

4. a) Does the Owner have any existing life insurance and/or annuity policies including any policies in the process of being surrendered or lapsed?
 Yes No If 'Yes', please complete the state appropriate replacement forms.

b) Provide information for each policy in force on the Proposed Life Insured with all companies. Not applicable

Company	Issue Date			To Remain in Force?		Amount
	month	day	year	Yes	No	
				<input type="checkbox"/>	<input type="checkbox"/>	\$
				<input type="checkbox"/>	<input type="checkbox"/>	\$
				<input type="checkbox"/>	<input type="checkbox"/>	\$

c) Have you ever had an application for life or long term care insurance declined, postponed, rated substandard or offered with a reduced amount?
 No Yes – If 'Yes', give details _____

SPECIAL REQUESTS - Attach additional page if more space is required.

5.

POLICY DETAILS

- 6. a) Face Amount \$ **500,000** _____ b) Single Premium \$ **100,000** _____
- c) Acceleration Benefit Rider Yes No
 Continuation of Acceleration Benefit Rider Yes No
 Total Acceleration Benefit Period
 2 Years 3 Years 4 Years 5 Years 6 Years 7 Years
 Years 4, 5, 6 or 7 are only available when the Continuation of Acceleration Benefit Rider is selected.
- d) Optional Riders Accelerated Death Benefit (for terminal illness)
 Other _____

FINANCIAL QUESTIONS

- 7. a) Gross annual income (salary, commissions, bonuses, etc.) \$ **500,000** _____
 b) Net worth \$ **5,000,000** _____
- 8. What is the source of the premiums for this policy? **SELF FUNDED** _____

LIFESTYLE QUESTIONS

- 9. Have you smoked cigarettes during the past 12 months? Yes No
 If 'Yes', how many in a week? _____
- 10. Do you engage in regular exercise? Yes No
- 11. Do you expect to travel outside of the U.S. or Canada, or change your country of residence in the next 2 years? Yes No
- 12. a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes in the last 2 years? Yes No
 b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, boxing, or any other hazardous activities in the last 2 years? Yes No
- 13. a) Have you been cited for one or more driving violations, other than parking tickets, within the last 3 years? Yes No
 b) Have you been cited for driving while intoxicated or while otherwise impaired? Yes No
- 14. In the past 10 years, have you been convicted of a felony offense? Yes No

Details for 'Yes' answers to Lifestyle Questions 10 - 14.

Question No.	Question No.		

INFORMATION REGARDING LAST MEDICAL CONSULTATION

16. a) Date of last visit to ANY doctor/physician JAN 15 2009
month day year
- b) Reason for visit ANNUAL CHECK-UP
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed NONE
- e) Name of doctor/physician for above
 Primary doctor/physician
 Other doctor/physician
- | | | |
|-------------------|--------|-----------|
| First | Middle | Last |
| Street No. & Name | | Suite No. |
| City | State | Zip Code |
- f) List of all medications and dosages you are currently taking including prescription and non-prescription drugs.

HEALTH QUESTIONS

17. Have any of your immediate family members (parents, brothers or sisters) prior to age 60:
- a) been diagnosed or died from coronary artery disease, stroke or cancer? Yes No
- b) been diagnosed with polycystic kidney disease or Huntington's chorea? Yes No
18. a) Your Height _____ Your Weight _____
- b) Has your weight changed 10 pounds or more in the past 2 years? Yes No
19. **Within the last 10 years, have you had symptoms of, received medical advice, diagnosis or treatment, or consulted or been treated by a member of the medical profession for any of the following conditions:**
- a) Chest pain, angina, congestive heart failure, coronary artery disease, cardiomyopathy, heart attack, shortness of breath, heart murmur, high blood pressure, irregular heart beat, atrial fibrillation, heart valve disease or any other disease or disorder of the heart or arteries? Yes No
- b) Diabetes, elevated blood sugar or glucose intolerance, thyroid, or any other endocrine or gland disease? Yes No
- c) Any nervous, mental illness or emotional disorder, schizophrenia, or received counseling for anxiety, depression, stress, or any other emotional condition? Yes No
- d) Gout, chronic fatigue, fibromyalgia, polymyalgia rheumatica, lupus, neuropathy, or any other skin, nerve or joint disorders? Yes No
- e) Asthma, sleep apnea, bronchitis, pneumonia, emphysema, chronic obstructive lung disease or any other lung disorder? Yes No
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, Crohn's disease, or other disease of the liver, gall bladder, pancreas, stomach, intestines or digestive system? Yes No
- g) Disease of the prostate, testicles, uterus, cervix, ovaries or breasts? Yes No
- h) Anemia, bleeding or clotting disorder, recurrent infection, or any problem, disease or disorder of the immune system, blood, blood cells or bone marrow or any lymph node disorders? Yes No
- i) Disease of the urinary tract, bladder, kidneys, sugar, protein or blood in the urine or any other genitourinary disorders? Yes No
- j) Cancer, leukemia, lymphoma, malignant melanoma, tumors, or cysts of any kind, malignant or benign? Yes No
- k) Any disease of the eye, ear, nose or throat? Yes No
- l) Any other health impairment or medically treated condition? Yes No
20. **Within the last 10 years have you had:**
- a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness, disease or accident? Yes No
- b) any diagnostic tests (e.g. blood, urine, EKGs, x-rays etc), whether conducted on an in-patient or out-patient basis? Yes No
21. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Life Insured, authorize:

1. The Company to obtain an investigative consumer report on me.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, the MIB, Inc. or any other similar person or organization to give The Company and its reinsurers information about me.

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

I further authorize The Company to disclose such information and any information developed during its evaluation of my application to: (a) its reinsurers; (b) the MIB, Inc.; (c) other insurance companies as designated by me; (d) me; (e) my insurance agent, when that agent is seeking insurance coverage through The Company on my behalf; (f) any medical professional designated by me; or (g) any person or entity entitled to receive such information by law or as I may further consent.

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

This authorization will be valid for two years from the date shown below. A photocopy of this authorization will be as valid as the original. Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

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

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

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

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Signature of Owner

Signature of Proposed Life Insured (if other than Owner)

X

X

Agent signature

Signature of Agent/Registered Representative

Signed this

Day of

Year

X



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

Complete and submit with LifeCare Application for Life Insurance.

PROPOSED LIFE INSURED

1. a) Name JOHN M. DOE
First Middle Last

AGENT QUESTIONS

To be completed by the Agent/Registered Representative.

- Does the Owner have any existing life insurance and/or annuity policies including any policies in the process of being surrendered or lapsed?
 Yes No If 'Yes', I have presented and read the state appropriate replacement forms to the Owner and have submitted them with the application.
- a) Did you meet with the client in person? Yes No If 'No', complete 2 b).
 b) Describe how this business was solicited. _____
- Agent Information

Name of Agent/Entity	Agent Code	Social Security No.	Telephone No.	E-mail Address	% Share
JOHN J. CORCORAN	99999	987654321	905 123-6900		100 %

Name of Broker Dealer (if applicable) _____ **Total must equal 100%**

CERTIFICATION AND SIGNATURE

Agent/Registered Representative for this policy must sign this form.

I declare that I know nothing affecting the insurability of the Proposed Life Insured which is not fully recorded in this application or the application supplement.
 I certify that the Buyer's Guide, Outline of Coverage, Notice of Disclosure, and an Illustration were given to the Owner at time of application and that no sales material other than that approved by The Company was used.

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Signature of Agent/Registered Representative

X _____