

SERFF Tracking Number: MANU-126275171 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 43291
Company Tracking Number: NB5120US (07/2009)
TOI: L071 Individual Life - Whole Sub-TOI: L071.111 Single Premium - Single Life
Product Name: NB5120US (07/2009)
Project Name/Number: NB5120US (07/2009)/NB5120US (07/2009)

Filing at a Glance

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

Product Name: NB5120US (07/2009)

SERFF Tr Num: MANU-126275171 State: Arkansas

TOI: L071 Individual Life - Whole

SERFF Status: Closed-Approved-
Closed State Tr Num: 43291

Sub-TOI: L071.111 Single Premium - Single Life Co Tr Num: NB5120US (07/2009)

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Michelle Fluet, Helene

Disposition Date: 08/21/2009

Landow, Karren Phair, Debbie Tom,

Jacqueline Lau, Joel Meggs

Date Submitted: 08/20/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: NB5120US (07/2009)

Status of Filing in Domicile: Authorized

Project Number: NB5120US (07/2009)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Exempt in
Michigan.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/21/2009

Explanation for Other Group Market Type:

State Status Changed: 08/21/2009

Deemer Date:

Created By: Debbie Tom

Submitted By: Debbie Tom

Corresponding Filing Tracking Number:

Filing Description:

INDIVIDUAL LIFE

NB5120US (07/2009) –LifeCare Application for Life Insurance

We are filing the above-referenced form for approval in your jurisdiction. The form is filed in accordance with the applicable statutes and regulations of your jurisdiction. This form is new and is not intended to replace an existing form. The form will be effective on the date of approval. No part of this filing contains any unusual or controversial items from

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 normal Company or industry standards

Application form NB5120US (07/2009), LifeCare Application for Life Insurance, will be used to apply for Single Premium Whole Life insurance policies which are offered by the Company on a simplified underwriting basis. The form will be available electronically to print locally without change in format or content.

This application will be used in a tele-app process. In a telephone interview, the applicant will be asked to provide the answers to the questions found on this application. Each question will be asked by the vendor using the exact wording for the question as it appears on the application. The applicant will receive a pre-populated application for signature in which the information that appears on the application is based on the applicant's answers to questions asked through the telephone interview. Reflexive underwriting questions may be utilized following affirmative responses during this process. These reflexive questions are available for the Department's inspection, if so desired.

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

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 CoCode: 65838 State of Domicile: Michigan
 (U.S.A.)
 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]

Filing Fees

Fee Required? Yes
 Fee Amount: \$20.00
 Retaliatory? No
 Fee Explanation:

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Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---------|----------------|---------------|
| John Hancock Life Insurance Company (U.S.A.) | \$20.00 | 08/20/2009 | 30001604 |

| CHECK NUMBER | CHECK AMOUNT | CHECK DATE |
|--------------|--------------|------------|
| | \$0.00 | |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 08/21/2009 | 08/21/2009 |

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Disposition

Disposition Date: 08/21/2009

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 | Life & Annuity - Actuarial Memo | | No |
| Supporting Document | Statement of Variability | | Yes |
| Form | LifeCare Application for Life Insurance | | Yes |

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Form Schedule

Lead Form Number:

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|--------------------|------------------------------|---|---------|----------------------|-------------|--------------|
| | NB5120US (07/2009) | Application/ Enrollment Form | LifeCare Application for Life Insurance | Initial | | 42.000 | NB5120US.pdf |



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) Will the insurance applied for in this application replace existing policies, or is the Owner considering using funds from existing policies to pay premiums due on the new policy or contract?
 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.

- Will the insurance applied for in this application replace existing policies, or is the Owner considering using funds from existing policies to pay premiums due on the new policy or contract?
 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 _____

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Supporting Document Schedules

| | Item Status: | Status Date: |
|--|--------------|--------------|
| Satisfied - Item: Flesch Certification Comments: Attachment: flesch ar.pdf | | |
| Bypassed - Item: Application Bypass Reason: not applicable Comments: | | |
| Bypassed - Item: Life & Annuity - Acturial Memo Bypass Reason: not applicable Comments: | | |
| Satisfied - Item: Statement of Variability Comments: Attachment: Statement of Variability US.pdf | | |

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

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

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

| FORM NUMBER | READABILITY SCORE |
|--------------------|--------------------------|
| NB5120US (07/2009) | 42 |

August 20, 2009
Date



Helene Landow, FLMI, ACP
Director, Contracts and Compliance

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

STATEMENT OF VARIABILITY

August 20, 2009

LIFECARE APPLICATION FOR LIFE INSURANCE

FORM NB5120US (07/2009)

| 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. |