

SERFF Tracking Number: MANU-126589691 State: Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) State Tracking Number: 45469
Company Tracking Number: PS5160US (04/2010)
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: PS5160US (04/2010)
Project Name/Number: PS5160US (04/2010)/PS5160US (04/2010)

Filing at a Glance

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

Product Name: PS5160US (04/2010)

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: MANU-126589691 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45469

Co Tr Num: PS5160US (04/2010) State Status: Approved-Closed

Reviewer(s): Linda Bird

Authors: Helene Landow, Karren

Phair, Debbie Tom, Jacqueline Lau

Date Submitted: 04/20/2010

Disposition Date: 04/21/2010

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: PS5160US (04/2010)

Project Number: PS5160US (04/2010)

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/21/2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/21/2010

Created By: Jacqueline Lau

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Jacqueline Lau

Filing Description:

INDIVIDUAL LIFE

Form PS5160US (04/2010) - Adding Benefits and Policy Changes that Require Underwriting Approval

We are submitting the above form for your approval. This form will be used with state approved contracts. This new form does not replace any currently approved forms and will be made available electronically to print locally without any change in the pre-formatted content. No part of this filing contains any unusual or controversial items that deviate from normal Company or industry standards.

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PS5160US (04/2010), Adding Benefits and Policy Changes that Require Underwriting Approval will be used for in-force policies on a closed block of business when a policy owner wishes to request reinstatement in accordance with the policy provisions for reinstatement following default and/or request policy changes where underwriting review and approval is required.

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

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

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

Company and Contact

Filing Contact Information

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

Filing Company Information

John Hancock Life Insurance Company CoCode: 65838 State of Domicile: Michigan
(U.S.A.)
P. O. Box 600 Group Code: 904 Company Type: insurance/financial
Contracts and Compliance 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: \$50.00
Retaliatory? No
Fee Explanation:

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Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company (U.S.A.)	\$50.00	04/20/2010	35802493

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/21/2010	04/21/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Adding Benefits and Policy Changes that Require Underwriting Approval	Jacqueline Lau	04/21/2010	04/21/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Disregard Note from 04-19-2010 for Withdraw Request	Note To Reviewer	Jacqueline Lau	04/21/2010	04/21/2010
Withdraw Request	Note To Reviewer	Jacqueline Lau	04/20/2010	04/20/2010

SERFF Tracking Number: MANU-126589691 State: Arkansas
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Disposition

Disposition Date: 04/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MANU-126589691 State: Arkansas
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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
Form (revised)	Adding Benefits and Policy Changes that Require Underwriting Approval		Yes
Form	Adding Benefits and Policy Changes that Require Underwriting Approval	Replaced	Yes

SERFF Tracking Number: MANU-126589691 *State:* Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) *State Tracking Number:* 45469
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TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: PS5160US (04/2010)
Project Name/Number: PS5160US (04/2010)/PS5160US (04/2010)

Note To Reviewer

Created By:

Jacqueline Lau on 04/21/2010 10:00 AM

Last Edited By:

Linda Bird

Submitted On:

04/21/2010 02:52 PM

Subject:

Disregard Note from 04-19-2010 for Withdraw Request

Comments:

Dear Ms. Bird,

Thank you for speaking to me this morning. As confirmed, we do not want to withdraw this filing. I have attached the correct application form for your state's review and approval in the usual manner.

Thank you.

Sincerely,

Jacqueline Lau

SERFF Tracking Number: MANU-126589691 State: Arkansas
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Amendment Letter

Submitted Date: 04/21/2010

Comments:

Dear Ms. Bird,

We have attached the corrected application form.

Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
PS5160US (04/2010)	Application/Enrollment Form	Benefits and Policy Changes that Require Underwriting Approval	Initial				0.000	PS5160US_A R_042010.pdf

SERFF Tracking Number: MANU-126589691 *State:* Arkansas
Filing Company: John Hancock Life Insurance Company (U.S.A.) *State Tracking Number:* 45469
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TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: PS5160US (04/2010)
Project Name/Number: PS5160US (04/2010)/PS5160US (04/2010)

Note To Reviewer

Created By:

Jacqueline Lau on 04/20/2010 12:22 PM

Last Edited By:

Linda Bird

Submitted On:

04/21/2010 02:52 PM

Subject:

Withdraw Request

Comments:

Hi,

I would like to withdraw this filing. Could you please acknowledge. Thank you.

SERFF Tracking Number: MANU-126589691 State: Arkansas
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 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: PS5160US (04/2010)
 Project Name/Number: PS5160US (04/2010)/PS5160US (04/2010)

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	PS5160US (04/2010)	Application/ Enrollment Form	Adding Benefits and Policy Changes that Require Underwriting Approval	Initial		0.000	PS5160US_A R_042010.pdf



LIFE INSURANCE

Adding Benefits and Policy Changes That Require Underwriting Approval

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

Mail your request to:

Customer Service Center R-02
John Hancock Life Insurance Company (U.S.A.)
1 John Hancock Way Suite 1350
Boston, MA 02117 - 1099

- A completed Health Questionnaire, NB5002 must be submitted for a Request for Reinstatement.

Section A - Owner/Life Insured Information

1. a) Name of Owner(s) JOHN M. DOE b) Policy/Contract Number 12345678

b) Address of Owner 1999 MARCH STREET ANYTOWN, ANYSTATE 12345 Please check for address change

2. a) Name of Insured JOHN M. DOE

b) Home Phone No. (905) 123-4567 c) Fax Number (905) 123-8976 d) Social Security No./ Tax Identification No. _____

Section B - Request for Reinstatement

Reinstatement is dependent on the following conditions being met:

- It is understood and agreed that, if reinstated, the policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness, if such coverage is provided by the policy, may begin after such date.
- It is hereby declared and agreed that the person named as Insured(s) and the persons named as family members covered by the policy are in good health and that during the time, including the grace period, since the first premium now in default became due, have had no injury, ailment, illness or diseases, or symptoms of such, and have not consulted or been treated by a physician or any other practitioner, except as otherwise provided below:

All exceptions have been stated.

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. a) Has mailing address changed since default occurred? Yes No

b) Premium Payor's Street Address, City, State, Zip code Current Address _____

2. a) Has there been any change in your occupation? Yes No

b) If **Yes**, state exact duties _____ Date change in occupation took place

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

c) Name and address Street Address, City, State, Zip code of new employer _____

3. a) Are any of the persons named as covered family members in the above policy to be excluded on this reinstatement? Yes No

b) If **Yes** give the name of the person and the reason for omission.
Name _____ Reason _____

4. Earned Income from your occupation - Current Calendar Year * \$ _____ Prior Calendar Year \$ _____
*Income should be projected for the remainder of the year from the date of this request.

5. Do you have any Individual Disability or Group LTD in force? Yes No If **Yes**, complete information below.

Type of Coverage	Monthly Amount	Elimination Period	Benefit Period
	\$		
	\$		

Section C - Request for an Additional Benefit

All increases are subject to income verification and your policy's provisions, including but not limited to, the timing of when an increase may be allowed and the minimum and maximum amounts that may be requested.

Please answer all of the following questions.

1. Requested additional amount of Monthly Income under the following provision of the above numbered policy \$ 200.00

Future Earning Protection Benefit	Maximum Amount for which Applicant Qualifies
<input checked="" type="checkbox"/> a) Term addition	<input type="checkbox"/>
<input type="checkbox"/> b) Permanent addition	<input type="checkbox"/>
<input type="checkbox"/> c) Other Special Request (Specify with Amount Requested)	

2. Effective Date*

month 4	day 15	year 2010
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 * For Section C, this is the next Option Date.

3. Is Insured now disabled? Yes No If **Yes**, give details:

4. a) What are all the present occupations of the Insured? (Describe duties) PHYSICIAN - GENERAL PRACTICE

b) Name of Firm(s) or Employers(s) MGH

c) Address(es) of Firm(s) or Employer(s) Street Address, City, State, Zip code FRUIT ST BOSTON, MA

5. What is the Insured's annual income (after business expenses, but individual income tax) for the periods specified?

a) Earned income

b) Unearned income, such as interest, investment income, pensions, rental income, etc.

Current Calendar Year*	Prior Calendar Year	Calendar Year Two Years Prior
\$ 65,000	\$ 55,000	\$ 50,000
\$ 5,000	\$ 4,500	\$ 4,000

*Income should be projected for the remainder of the year from the date of this request.

c) Sources of unearned income INVESTMENTS

d) Estimated Net Worth \$ 100,000

6. What is total amount of disability income insurance in force in all companies? (Include individual, group and association coverage but do not include coverage under above-numbered policy.)

Company or Organization	Monthly Amount		How long payable
	Basic	SIR	
JH	\$ 2,500	\$ —	TO AGE 65
	\$	\$	
	\$	\$	

7. a) Does the Insured have any other applications pending for disability income insurance? Yes No

b) If **Yes** give details

Section D - Request to Increase Supplemental Business Overhead Expense Disability Coverage

The Statements and Answers in the Request to Increase Supplemental Business Overhead Disability Policy constitute a part of the statements and answers in the application for Insurance applied for by the Proposed Life Insured this date and shall be subject to the terms and conditions of said applicant.

Please answer all of the following questions.

1. Proposed Insured? First Name, Middle Initial, Last Name
Print) _____

2. a) Maximum Monthly Benefit \$ _____ b) Maximum Total Benefit? \$ _____

3. Do you understand and agree: a) that not more than the Maximum Monthly Benefit will be payable on account of covered overhead expenses accrued during each month for which benefits are payable under the policy? Yes No
 b) that no benefit is payable for any waiting period? Yes No

4. Are you a partner in your business or profession? Yes No If **Yes** what is your share of the expenses? _____ %

5. Are any of your overhead expenses incurred through joint occupancy? Yes No If **Yes**, specify which expenses are incurred jointly and your percentage share. _____ %

6. Are any of your overhead expenses incurred through a corporation? Yes No If **Yes**, what is your ownership interest? _____ %

7. Do you carry or are you now applying for overhead expense insurance in any other company or business association? Yes No
 If **Yes**, give the name of the company or association and the amount in force or applied for: _____ \$

8. What are your actual monthly overhead expenses? (If a partner or joint occupant, include only your share of the expenses. If a corporation, multiply the expenses by the percentage given in answer to question 5 and enter the result.)

a) Rent and mortgages \$ _____ b) Electricity, telephone, heat and water \$ _____ c) Employee's salaries \$ _____ d) Cleaning of uniforms \$ _____ e) Postage and periodicals \$ _____ f) Membership fees and dues to professional societies and trade associations \$ _____ g) Accountants' and auditors' fees \$ _____ h) Depreciation and maintenance of business equipment \$ _____	i) Property taxes \$ _____ j) Property and liability insurance premiums \$ _____ k) Other fixed expenses which are ordinary and necessary in the operation of the business premises: \$ _____ \$ _____ \$ _____ \$ _____ Total of all listed expenses \$ _____
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Note: Exclude salaries, fees, drawing accounts, profits, or any remuneration for yourself, any partner, any member of your profession, any person hired to perform your duties or any person who is a member of your immediate family (parent, spouse, brother, sister, child or anyone who ordinarily lives in your home), income taxes, payment on principal of any indebtedness, or the cost of any business equipment, furniture, furnishings and fixtures, goods, merchandise or pharmaceutical products.

Remarks

Section E - Other Request and/or Explanation

Comments

Section F - 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 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.

Section G - Signatures

I/We have read all of the above Instructions and form section related to the policy change being requested. All statements and answers in this form are correctly recorded and are completed and true to the best of my/our knowledge and belief. The policy change(s) requested is/are subject to the provisions and conditions of the policy. I/We, as owner(s) of this policy, understand that the changes requested may impact this policy's values, secondary guarantees, as well as the duration in which the policy remains inforce. I/we understand that all changes are subject to The Company's review and approval.

In addition, no agent is permissible of the following:

- a) Waive or change any of the conditions or provisions of the policy or this Application; and/or
- b) Pass upon insurability.

Signed at	City	State	This	Day of	Year	

Name of Insured (Please print)				Signature of Insured		
_____				x		
Name of Owner(s) (Please print)				Signature of Owner(s)		
_____				x		
Title of Owner (required For Corporate Owned or Trust Owned)				Signature of Assignee		
_____				x		
Signature of Agent/Registered Representative				Signed this	Day of	Year
_____				_____	_____	_____
x						

Agent Report - Credit for Application

Agency Name _____ Ord Code _____ GA's Initials _____ City Tax _____

Supervisor or Staff Manager's Name	Supervisor or Staff Manager No.	Agent's Name	Contract No.	Agent No.	Percentage %

Section H - FRAUD WARNING - Read the Fraud Warning for your state.

Arkansas: Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurer or other person, 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, which is a crime.

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

Maine, Tennessee, Virginia and Washington: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who knowingly and with the 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, is committing a fraudulent insurance act.

Oklahoma: FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For all other states: Any person who knowingly and with intent to defraud any insurer, files an application for insurance or statement of claim containing 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.

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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.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
PS5160US (04/2010)	40*

*Joint score for application and policy combined.

April 20, 2009
Date


Helene Landow, FLMI, ACP
Director, Contracts and Compliance

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

STATEMENT OF VARIABILITY

April 20, 2010

Adding Benefits and Policy Changes That Require Underwriting Approval

FORM PS5160US (04/2010)

Section/Section #	Page Number	Description
Service Office at top of page.	Page 1	The address of the Company's Service Office is bracketed as it may be changed in the future. A current Service Office address will always appear on the form.
Fraud Warnings	Page 5	State specific fraud language varies based on state regulation(s).

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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/20/2010	Form	Adding Benefits and Policy Changes that Require Underwriting Approval	04/21/2010	PS5160US_042010.pdf (Superseded)



LIFE INSURANCE

Adding Benefits and Policy Changes That Require Underwriting Approval

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

Mail your request to:

Customer Service Center R-02
John Hancock Life Insurance Company (U.S.A.)
1 John Hancock Way Suite 1350
Boston, MA 02117 - 1099

- A completed Health Questionnaire, NB5002 must be submitted for a Request for Reinstatement.

Section A - Owner/Life Insured Information

1. a) Name of Owner(s) JOHN M. DOE b) Policy/Contract Number 12345678

b) Address of Owner 1999 MARCH STREET ANYTOWN, ANYSTATE 12345 Please check for address change

2. a) Name of Insured JOHN M. DOE

b) Home Phone No. (905) 123-4567 c) Fax Number (905) 123-8976 d) Social Security No./ Tax Identification No. _____

Section B - Request for Reinstatement

Reinstatement is dependent on the following conditions being met:

- It is understood and agreed that, if reinstated, the policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness, if such coverage is provided by the policy, may begin after such date.
- It is hereby declared and agreed that the person named as Insured(s) and the persons named as family members covered by the policy are in good health and that during the time, including the grace period, since the first premium now in default became due, have had no injury, ailment, illness or diseases, or symptoms of such, and have not consulted or been treated by a physician or any other practitioner, except as otherwise provided below:

All exceptions have been stated.

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. a) Has mailing address changed since default occurred? Yes No

b) Premium Payor's Street Address, City, State, Zip code Current Address _____

2. a) Has there been any change in your occupation? Yes No

b) If **Yes**, state exact duties _____ Date change in occupation took place

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

c) Name and address Street Address, City, State, Zip code of new employer _____

3. a) Are any of the persons named as covered family members in the above policy to be excluded on this reinstatement? Yes No

b) If **Yes** give the name of the person and the reason for omission.
Name _____ Reason _____

4. Earned Income from your occupation - Current Calendar Year * \$ _____ Prior Calendar Year \$ _____
*Income should be projected for the remainder of the year from the date of this request.

5. Do you have any Individual Disability or Group LTD in force? Yes No If **Yes**, complete information below.

Type of Coverage	Monthly Amount	Elimination Period	Benefit Period
	\$		
	\$		

Section C - Request for an Additional Benefit

All increases are subject to income verification and your policy's provisions, including but not limited to, the timing of when an increase may be allowed and the minimum and maximum amounts that may be requested.

Please answer all of the following questions.

1. Requested additional amount of Monthly Income under the following provision of the above numbered policy \$ 200.00

Future Earning Protection Benefit	Maximum Amount for which Applicant Qualifies
<input checked="" type="checkbox"/> a) Term addition	<input type="checkbox"/>
<input type="checkbox"/> b) Permanent addition	<input type="checkbox"/>
<input type="checkbox"/> c) Other Special Request (Specify with Amount Requested)	

2. Effective Date*

month	day	year
4	15	2010

 * For Section C, this is the next Option Date.

3. Is Insured now disabled? Yes No If **Yes**, give details:

4. a) What are all the present occupations of the Insured? (Describe duties) PHYSICIAN - GENERAL PRACTICE

b) Name of Firm(s) or Employers(s) MGH

c) Address(es) of Firm(s) or Employer(s) Street Address, City, State, Zip code FRUIT ST BOSTON, MA

5. What is the Insured's annual income (after business expenses, but individual income tax) for the periods specified?

a) Earned income

b) Unearned income, such as interest, investment income, pensions, rental income, etc.

Current Calendar Year*	Prior Calendar Year	Calendar Year Two Years Prior
\$ 65,000	\$ 55,000	\$ 50,000
\$ 5,000	\$ 4,500	\$ 4,000

*Income should be projected for the remainder of the year from the date of this request.

c) Sources of unearned income INVESTMENTS

d) Estimated Net Worth \$ 100,000

6. What is total amount of disability income insurance in force in all companies? (Include individual, group and association coverage but do not include coverage under above-numbered policy.)

Company or Organization	Monthly Amount		How long payable
	Basic	SIR	
JH	\$ 2,500	\$ —	TO AGE 65
	\$	\$	
	\$	\$	

7. a) Does the Insured have any other applications pending for disability income insurance? Yes No

b) If **Yes** give details

Section D - Request to Increase Supplemental Business Overhead Expense Disability Coverage

The Statements and Answers in the Request to Increase Supplemental Business Overhead Disability Policy constitute a part of the statements and answers in the application for Insurance applied for by the Proposed Life Insured this date and shall be subject to the terms and conditions of said applicant.

Please answer all of the following questions.

1. Proposed Insured? First Name, Middle Initial, Last Name
Print) _____

2. a) Maximum Monthly Benefit \$ _____ b) Maximum Total Benefit? \$ _____

3. Do you understand and agree: a) that not more than the Maximum Monthly Benefit will be payable on account of covered overhead expenses accrued during each month for which benefits are payable under the policy? Yes No
 b) that no benefit is payable for any waiting period? Yes No

4. Are you a partner in your business or profession? Yes No If **Yes** what is your share of the expenses? _____ %

5. Are any of your overhead expenses incurred through joint occupancy? Yes No If **Yes**, specify which expenses are incurred jointly and your percentage share. _____ %

6. Are any of your overhead expenses incurred through a corporation? Yes No If **Yes**, what is your ownership interest? _____ %

7. Do you carry or are you now applying for overhead expense insurance in any other company or business association? Yes No
 If **Yes**, give the name of the company or association and the amount in force or applied for: _____ \$

8. What are your actual monthly overhead expenses? (If a partner or joint occupant, include only your share of the expenses. If a corporation, multiply the expenses by the percentage given in answer to question 5 and enter the result.)

a) Rent and mortgages \$ _____ b) Electricity, telephone, heat and water \$ _____ c) Employee's salaries \$ _____ d) Cleaning of uniforms \$ _____ e) Postage and periodicals \$ _____ f) Membership fees and dues to professional societies and trade associations \$ _____ g) Accountants' and auditors' fees \$ _____ h) Depreciation and maintenance of business equipment \$ _____	i) Property taxes \$ _____ j) Property and liability insurance premiums \$ _____ k) Other fixed expenses which are ordinary and necessary in the operation of the business premises: \$ _____ \$ _____ \$ _____ \$ _____ Total of all listed expenses \$ _____
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Note: Exclude salaries, fees, drawing accounts, profits, or any remuneration for yourself, any partner, any member of your profession, any person hired to perform your duties or any person who is a member of your immediate family (parent, spouse, brother, sister, child or anyone who ordinarily lives in your home), income taxes, payment on principal of any indebtedness, or the cost of any business equipment, furniture, furnishings and fixtures, goods, merchandise or pharmaceutical products.

Remarks

Section E - Other Request and/or Explanation

Comments

Section F - 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 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.

Section G - Signatures

I/We have read all of the above Instructions and form section related to the policy change being requested. All statements and answers in this form are correctly recorded and are completed and true to the best of my/our knowledge and belief. The policy change(s) requested is/are subject to the provisions and conditions of the policy. I/We, as owner(s) of this policy, understand that the changes requested may impact this policy's values, secondary guarantees, as well as the duration in which the policy remains inforce. I/we understand that all changes are subject to The Company's review and approval.

In addition, no agent is permissible of the following:

- a) Waive or change any of the conditions or provisions of the policy or this Application; and/or
- b) Pass upon insurability.

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

Name of Insured (Please print) _____ Signature of Insured _____

Name of Owner(s) (Please print) _____ Signature of Owner(s) _____

Title of Owner (required For Corporate Owned or Trust Owned) _____ Signature of Assignee _____

Signature of Agent/Registered Representative _____ Signed this _____ Day of _____ Year _____

Agent Report - Credit for Application

Agency Name _____ Ord Code _____ GA's Initials _____ City Tax _____

Supervisor or Staff Manager's Name	Supervisor or Staff Manager No.	Agent's Name	Contract No.	Agent No.	Percentage %

Section H - FRAUD WARNING - Read the Fraud Warning for your state.

Arkansas: Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurer or other person, 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, which is a crime.

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

Maine, Tennessee, Virginia and Washington: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who knowingly and with the 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, is committing a fraudulent insurance act.

Oklahoma: FRAUD WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For all other states: Any person who knowingly and with intent to defraud any insurer, files an application for insurance or statement of claim containing 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.