

SERFF Tracking Number: MULF-127180705 State: Arkansas
Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
Company Tracking Number: CCIII MGS1 APPLICATION
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII/MGS111 Application - CCIII

Filing at a Glance

Company: John Hancock Life Insurance Company (USA)

Product Name: Long-Term Care Insurance SERFF Tr Num: MULF-127180705 State: Arkansas
TOI: LTC03I Individual Long Term Care SERFF Status: Closed-Approved- State Tr Num: 48873
Closed

Sub-TOI: LTC03I.001 Qualified Co Tr Num: CCIII MGS1 State Status: Approved-Closed
APPLICATION

Filing Type: Form

Reviewer(s): Harris Shearer,
Stephanie Fowler

Authors: Glenn Daly, Pat Hamlett, Disposition Date: 06/27/2011
Joanne Witham

Date Submitted: 05/25/2011 Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: MGS1 Application - CCIII
Project Number: MGS111 Application - CCIII
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Our domicile state of Michigan is a member of the Interstate Insurance Compact Product Regulation Commission (IIPRC). This form has been submitted for review to the IIPRC.

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Individual Market Type:
Filing Status Changed: 06/27/2011
State Status Changed: 06/27/2011
Created By: Joanne Witham
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Pat Hamlett

Filing Description:

Individual Long-Term Care Insurance Submission - Application Form LTC-MGS111 AR

Dear Commissioner:

SERFF Tracking Number: MULF-127180705 State: Arkansas
Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
Company Tracking Number: CCIII MGS1 APPLICATION
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII/MGS11 Application - CCIII

We have enclosed the above referenced form for your review and approval. A description of this form is found below. This is a new application form to be used with our recently approved Custom Care III individual long-term care insurance policy form LTC-11 AR, approved by your department on 2/23/2011, SERFF# MULF-126977796. This application form LTC-MGS11 AR is for use with our Sponsored Group Discount program for employers and associations.

Please note that we continue to upgrade our form production and issue system to a new technology. This upgrade may in some instances slightly alter the appearance of our forms based upon the new technology and the printers used. In addition, from time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/completed/printed via website technology. Variable information is enclosed by brackets "[]". A statement of variability is attached.

This submission is being filed simultaneously with the Interstate Compact and remaining non-Compact states and the District of Columbia. We intend to implement this form once approved.

Please feel free to call me at 1-888-877-6075 or email me at phamlett@jhancock.com should you have any questions.

Thank you for your time and consideration in this matter.

Company and Contact

Filing Contact Information

Joanne Witham , jwitham@jhancock.com
200 Berkeley Street 617-572-0281 [Phone]
Boston, MA 02117 617-572-0399 [FAX]

Filing Company Information

John Hancock Life Insurance Company (USA) CoCode: 65838 State of Domicile: Michigan
200 Berkeley Street Group Code: Company Type:
Boston, MA 02176 Group Name: State ID Number:
(617) 572-6000 ext. [Phone] FEIN Number: 01-0233346

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00

SERFF Tracking Number: MULF-127180705 *State:* Arkansas
Filing Company: John Hancock Life Insurance Company (USA) *State Tracking Number:* 48873
Company Tracking Number: CCIII MGSII APPLICATION
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGSII Application - CCIII/MGSII1 Application - CCIII
Retaliatory? No
Fee Explanation: One application submitted - \$50.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company (USA)	\$50.00	05/25/2011	47991577
John Hancock Life Insurance Company (USA)	\$50.00	06/15/2011	48732592

SERFF Tracking Number: MULF-127180705 State: Arkansas
 Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
 Company Tracking Number: CCIII MGSI APPLICATION
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Long-Term Care Insurance
 Project Name/Number: MGSI Application - CCIII/MGSI11 Application - CCIII

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/27/2011	06/27/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Advance Payment Receipt	Joanne Witham	06/15/2011	06/15/2011
Supporting Document	Flesch Certification	Joanne Witham	06/15/2011	06/15/2011

SERFF Tracking Number: MULF-127180705 State: Arkansas
Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
Company Tracking Number: CCIII MGSII APPLICATION
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGSII Application - CCIII/MGSII1 Application - CCIII

Disposition

Disposition Date: 06/27/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MULF-127180705 State: Arkansas
 Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
 Company Tracking Number: CCIII MGSI APPLICATION
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Long-Term Care Insurance
 Project Name/Number: MGSI Application - CCIII/MGSI11 Application - CCIII

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Flesch Certification	Accepted for	Yes
		Informational Purposes	
Supporting Document	Flesch Certification	Replaced	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter	Accepted for	Yes
		Informational Purposes	
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Individual Long Term Care Application	Approved-Closed	Yes
Form	Advance Payment Receipt	Approved-Closed	Yes

SERFF Tracking Number: MULF-127180705 State: Arkansas
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 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Long-Term Care Insurance
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Amendment Letter

Submitted Date: 06/15/2011

Comments:

We are amending this submission to add an Advance Payment Receipt to the form schedule for your review and approval.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
LTC-CR11 6/11	Other	Advance Payment Receipt	Initial					LTC- CR116_11.pdf

Supporting Document Schedule Item Changes:

Satisfied -Name: Flesch Certification

Comment:

CERTIFICATION OF READABILITY6-15.pdf

SERFF Tracking Number: MULF-127180705 State: Arkansas
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Form Schedule

Lead Form Number: LTC-MGSI11 AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/27/2011	LTC-MGSI11	Application/ Enrollment Form	Individual Long Term Care Application	Initial			LTC-MGSI11 AR_app.pdf
Approved-Closed 06/27/2011	LTC-CR11 6/11	Other	Advance Payment Receipt	Initial			LTC-CR116_11.pdf

**APPLICATION FOR INDIVIDUAL
LONG-TERM CARE INSURANCE**

John Hancock Life Insurance Company (U.S.A.)
[1 John Hancock Place, Boston, MA 02217]



Control #

Control #

NAME(S): Applicant A (First, M.I., Last):

Applicant B (First, M.I., Last):

BUSINESS INFORMATION

Sponsoring Employer Name:

Street Address of Employer:

City:

State:

Zip Code:

[For Agent Use Only:

Applicant A

Applicant B

Underwriting Program:

Underwriting Program:

Simplified Full

Simplified Full

MGSI or Sponsored Group #:

MGSI or Sponsored Group #:]

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

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

[1 John Hancock Place, Boston, MA 02217]



The applicant(s) must initial any corrections made to the application.

PART 1 ABOUT YOU

APPLICANT A
1a. Name Last Name _____ First Name _____ M.I. _____
1b. Street Address Number Street, Apt. # _____ _____ City, State, Zip _____
1c. Contact Information Telephone # _____ Best Time To Call _____ AM _____ PM Email Address _____
1d. Place & Date of Birth Place _____ DOB (mm/dd/yyyy) _____
1e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
1f. Height _____' _____" Weight _____lbs
1g. Social Security Number _____-_____-_____

APPLICANT B
1a. Name Last Name _____ First Name _____ M.I. _____
1b. Street Address <input type="checkbox"/> Same as Applicant A Number Street, Apt. # _____ _____ City, State, Zip _____
1c. Contact Information Telephone # _____ Best Time To Call _____ AM _____ PM Email Address _____
1d. Place & Date of Birth Place _____ DOB (mm/dd/yyyy) _____
1e. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
1f. Height _____' _____" Weight _____lbs
1g. Social Security Number _____-_____-_____

The applicant(s) must initial any corrections made to this application.

PART 2 EMPLOYMENT INFORMATION

2a. Are you currently actively at work?

Yes No

You are "actively at work" if during the last 6 months you have worked for the sponsoring employer for a minimum of 30 hours per week and missed 10 days or less days during that time period due to illness, injury or infirmity. An employee on leave of absence or receiving Social Security Disability Income is not considered "actively at work".

2a. Are you currently actively at work?

Yes No

2b. Relationship to Employee

2b. Relationship to Employee

2c. Which applies to you?

Active Employee Newly Hired Employee
 Newly Eligible Employee Other
 Employee Returning form Leave

2c. Which applies to you?

Active Employee Newly Hired Employee
 Newly Eligible Employee Other
 Employee Returning form Leave

2d. Active Employee's Date of Hire/Eligibility

(mm/dd/yyyy) _____

2d. Active Employee's Date of Hire/ Eligibility

(mm/dd/yyyy) _____

PART 3 DISCOUNTS & OTHER NEEDED INFORMATION

3a. Beneficiary Designation

Please elect a beneficiary for the return of any unearned premium, and if you are age 64 or younger for the Return of Premium upon Death Benefit. If you leave this question blank, we will designate your estate as your beneficiary. You may change your beneficiary at any time by notifying us in writing.

Name & Address (for Applicant A) _____

Name & Address (for Applicant B) _____

	Applicant A		Applicant B	
	YES	NO	YES	NO
<i>Please check YES or NO beside each question below.</i>				
3b. Marital/Partner* Discount				
Are you married?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3c. Are you in a committed relationship with a Partner or live with an immediate family member of the same generation, with whom you have been living with for at least 3 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3d. Is your Spouse, Partner or immediate family member of the same generation also applying, or does he/she currently have an existing John Hancock individual LTC insurance policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, provide Policy #, Name, or SSN _____				
*Partner – means an unmarried individual, not related to you by blood or marriage that has lived with you in a committed relationship for at least 3-years.				

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

If you are an employee under age 65, applying for Modified Standard Issue, please complete Section A and skip to Part 5. If you are part of the full underwriting program, please complete all Parts of the application.

SECTION A – Should You Proceed with This Application?

	Applicant A		Applicant B	
	YES	NO	YES	NO
<i>Please check YES or NO beside each question below.</i>				
4a. Do you currently have, or have you ever been diagnosed by a medical professional for: (indicate all that apply) ▪ Alzheimer's Disease ▪ Amyotrophic Lateral Sclerosis ▪ Cystic Fibrosis ▪ Dementia ▪ Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney ▪ Huntington's Disease ▪ Memory Loss ▪ Mental Retardation ▪ Multiple Myeloma ▪ Multiple Sclerosis ▪ Muscular Dystrophy ▪ Myasthenia Gravis ▪ Parkinson's Disease ▪ Schizophrenia ▪ Scleroderma ▪ Spinal Cord Injury ▪ Stroke/CVA ▪ Transient Ischemic Attacks (TIAs) (2 or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. Do you require mechanical or human assistance or supervision in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, and bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4c. Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility, rehabilitation facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4d. Do you currently use one of the following medical devices: wheelchair, walker, hospital bed, quad cane, crutches, oxygen, stairlift, and dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4e. Have you been diagnosed or treated by a member of the medical profession for HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

If you answered YES to any of the questions in PART 4, SECTION A, we suggest you do not submit an application.
If you answered NO to every question, please continue.

If you are an employee under age 65, applying for Modified Standard Issue Program, skip to Part 5.

SECTION B – Medical History

	Applicant A		Applicant B	
	YES	NO	YES	NO
4f. Have you consulted with a Physician in the last 18 months? If Yes, provide the Physician's information below. If No, provide your Primary Care Physician's information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant A

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

Applicant B

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

		Applicant A		Applicant B	
		YES	NO	YES	NO
4g.	Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4h.	Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions? <i>Please indicate each that applies and provide details in the Medical History Details.</i>				
1.	Circulatory Disorders: Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms, Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Endocrine and Pituitary Disorders: Diabetes, Addison’s Disease, Pancreatitis, Cushing’s Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Cancers: Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas, Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Genitourinary Disorders: Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Gastrointestinal Disorders: Hepatitis, Ulcerative Colitis, Crohn’s Disease, Liver Disorders, Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Neurological Disorders: Cerebral Atrophy, Cerebral Palsy, Mental Illness, Mental Retardation, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome, Dementia, Alzheimer’s Disease, Amyotrophic Lateral Sclerosis, Memory Loss, Multiple Sclerosis, Parkinson’s Disease, Huntington’s Disease, Muscular Dystrophy, Myasthenia Gravis, Schizophrenia, Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Blood Disorders: Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Musculoskeletal Disorders: Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Polymyalgia Rheumatica, Osteopenia, Paralysis, Crest, Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Respiratory Disorders: Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Eye & Ear Disorders: Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere’s/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Substance Abuse: Alcoholism, Drug dependency, Illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4i.	Within the last 5 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4j.	Within the last 5 years, has any surgery or test(s) been recommended that have not been performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4k.	Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated? (If YES, provide details on next page.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

	Applicant A		Applicant B	
	YES	NO	YES	NO
4l. Have you applied for or are you receiving any disability benefits? Type _____ Percentage _____ Medical Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4m. Does/Did any of your family members (mother, father or siblings) have any of the following? (Please indicate all that apply) ▪ Alzheimer’s Disease ▪ Amyotrophic Lateral Sclerosis (Lou Gehrig’s) ▪ Dementia ▪ Diabetes ▪ Heart Disease ▪ Huntington’s Disease ▪ Parkinson’s Disease ▪ Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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[LIFESTYLE (PLEASE COMPLETE THIS SECTION IF YOU ARE 64 OR YOUNGER.)

4n. Are you currently employed? If yes, what is your occupation? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4o. In the past 10 years have you done or in the future, do you intend to do any of the following activities? Skin/scuba Diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? Frequency? Applicant A: Activity Type _____ Frequency Per Year _____ Applicant B: Activity Type _____ Frequency Per Year _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4p. In the past 10 years, have you been convicted of two or more felony motor vehicle moving violations or had a drivers license suspended or revoked? If yes, license # and state. Applicant A _____ Applicant B _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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MEDICAL HISTORY DETAILS

If you answered YES to any of questions 4h-4l, provide full details below. Attach a separate sheet if you need additional space.

Applicant A

Diagnosis/ Disorder/ Reason	Diagnosis Date	Treatment Date(s)	Name, Address, Tel# of Physician, Provider, and/or Insurer (if applicable) and Comments

Applicant B

Diagnosis/ Disorder/ Reason	Diagnosis Date	Treatment Date(s)	Name, Address, Tel# of Physician, Provider, and/or Insurer (if applicable) and Comments

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

MEDICAL HISTORY DETAILS

If you answered YES to 4m provide full details below. Attach a separate sheet if you need additional space.

Applicant A

Diagnosis	Relationship (e.g. Mother)	Age of Onset

Applicant B

Diagnosis	Relationship (e.g. Mother)	Age of Onset

4q. MEDICATIONS

List all prescription medications taken or that have been prescribed to you at any time over the past 18 months.

Applicant A	Dosage	Frequency	Reason Prescribed	Physician Name

Applicant B

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

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

PART 5 COVERAGE SELECTION - [Custom Care III]

Modified Standard Issue Program – Maximum benefit limits [\$200]Daily Benefit or \$6,000 Monthly Benefit and Benefit Period up to [5] Years. [30 Day Elimination Period is not available.] Optional Benefits limited to [Shared Care and Nonforfeiture.]

5a. Benefit Amount (select either Daily or Monthly)	Applicant A	Applicant B
<input type="checkbox"/> Daily Benefit (\$50-\$500 in \$10 increments)	\$	\$
<input type="checkbox"/> Monthly Benefit Amount (\$1,500 -\$15,000 in \$100 increments)		
5b. Benefit Period (select one)	<input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 6 Years <input type="checkbox"/> 10 Years	<input type="checkbox"/> 2 Years <input type="checkbox"/> 3 Years <input type="checkbox"/> 4 Years <input type="checkbox"/> 5 Years <input type="checkbox"/> 6 Years <input type="checkbox"/> 10 Years]
5c. Elimination Period (Dates of Service)	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days	<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days]
5d. Inflation Protection Options <i>* This is the default if you do not select an inflation option. This choice includes a Guaranteed Purchase Option, if you select Survivorship and Waiver of Premium, or a Limited Payment Option with this option a benefit increase option will not be offered to you.</i>	<input type="checkbox"/> CPI Compound Inflation <input type="checkbox"/> CPI Compound to Age 75 <input type="checkbox"/> 5% Compound Inflation <input type="checkbox"/> 3% Compound Inflation <input type="checkbox"/> Guaranteed Purchase Option *	<input type="checkbox"/> CPI Compound Inflation <input type="checkbox"/> CPI Compound to Age 75] <input type="checkbox"/> 5% Compound Inflation <input type="checkbox"/> 3% Compound Inflation <input type="checkbox"/> Guaranteed Purchase Option *]
Rejection of Inflation I have reviewed the outline of coverage and the graphs that compare benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the 5% Compound Inflation and I reject this inflation option.	<i>You must check the box below if you did not select 5% Compound Inflation.</i> <input type="checkbox"/> I reject 5% Compound Inflation	<i>You must check the box below if you did not select 5% Compound Inflation</i> <input type="checkbox"/> I reject 5% Compound Inflation
5e. Optional Benefits	<input type="checkbox"/> Shared Care <input type="checkbox"/> Survivorship and Waiver of Premium <input type="checkbox"/> Waiver of HHC Elimination Period <input type="checkbox"/> Additional Cash Benefit <input type="checkbox"/> Nonforfeiture	<input type="checkbox"/> Shared Care <input type="checkbox"/> Survivorship and Waiver of Premium <input type="checkbox"/> Waiver of HHC Elimination Period <input type="checkbox"/> Additional Cash Benefit] <input type="checkbox"/> Nonforfeiture
Rejection of Nonforfeiture I have reviewed the outline of coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.	<i>You must check the box below if you did not select Nonforfeiture.</i> <input type="checkbox"/> I reject Nonforfeiture	<i>You must check the box below if you did not select Nonforfeiture.</i> <input type="checkbox"/> I reject Nonforfeiture

PART 6 PREMIUM PAYMENT & ADMINISTRATION

	Applicant A	Applicant B
6a. Who will be paying the premium?	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.
6b. Premium Payment Type	<input type="checkbox"/> Standard Pay <input type="checkbox"/> 20-Year Limited Payment Option <input type="checkbox"/> Paid-up at Age 75 Limited Payment Option	<input type="checkbox"/> Standard Pay <input type="checkbox"/> 20-Year Limited Payment Option <input type="checkbox"/> Paid-up at Age 75 Limited Payment Option]
6c. Payment Method	<i>Please select one of the following for each applicant.</i>	
[1. Direct Bill (select a mode of billing)	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly
2. Monthly Bank Draft <i>Please include a voided check and complete form LTC-7269R.</i>	<input type="checkbox"/> Monthly Bank Draft (Electronic Fund Transfer)	<input type="checkbox"/> Monthly Bank Draft (Electronic Fund Transfer)
An Advance Payment is required.		
<input type="checkbox"/> I have enclosed my advance payment in the amount of \$_____ (minimum of one month's modal premium)		
<i>Please make checks payable to John Hancock Life Insurance Company (U.S.A.). Do not make check payable to the agent or leave the payee blank. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.</i>		
3. List Bill	<i>Please check box:</i> <input type="checkbox"/> List Bill	<input type="checkbox"/> List Bill
Group Number:	_____	_____
Group Name:	_____	_____]

PART 7 INSURANCE HISTORY

	Applicant A		Applicant B	
	YES	NO	YES	NO
7a. Are you covered by Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b. Have you had another LTC insurance policy/certificate in-force during the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, insurance company name: _____		_____		
If lapsed, date of lapse: _____		_____		
7c. Do you have another LTC insurance policy or certificate in-force (including a healthcare service, health maintenance, or Medicare supplement contract)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, insurance company name: _____		_____		
Policy/certificate #: _____		_____		
Annual premium: \$ _____		\$ _____		
Daily benefit: \$ _____		\$ _____		
LTC insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
7d. Do you intend to replace any of your LTC, medical or health insurance coverage with the policy for which you are applying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If YES, insurance company name: _____		_____		

PART 8 PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to name another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A

- I elect NOT to designate any person to receive such notice, or
 I elect to designate the person below to receive such notice.

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

Applicant B

- I elect NOT to designate any person to receive such notice, or
 I elect to designate the person below to receive such notice.

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

PART 9 SPECIAL REQUESTS

PART 10 DECLARATION AND AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

1. I have received the Outline of Coverage, Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacing coverage) and the Guide to Health Insurance for People with Medicare (if eligible for Medicare).
2. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
3. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
4. John Hancock Life Insurance Company (U.S.A.) ("John Hancock") may require an attending physician statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
5. My statements and answers on this application are true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

1. Completing this application or making an advance payment is not a guarantee that my application will be approved. If approved, the effective date will be indicated in the policy issued.
2. If my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.
3. If making an advance payment, my check(s) will be held in a non-interest bearing account while John Hancock reviews this application for acceptance.
4. By making an advance payment by check with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. In addition, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen. [The following provision is applicable to payroll deduction, list bill or employer-paid plans where no advance payment is required: I understand that my health status will not be frozen when no advance payment is made. I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.)]
5. If bank draft is the selected method of payment, the first draft will occur on the premium due date after my policy has been issued. Subsequent drafts will occur on the selected draft day requested in Part 6 of this application.
6. In order to keep my policy in force, I must pay all the required premiums when due. The premium deducted or charged will be as shown on the policy or the most recent change notice issued to the policyholder by John Hancock.
7. I understand that premium rates are not guaranteed and may be increased in the future if I am among the group of policyholders whose premiums are determined to be inadequate.
8. I authorize John Hancock to deduct from my bank all required premiums, based upon my selected method of payment as shown in Part 6, indefinitely until I provide written notice of cancellation to John Hancock at servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A) MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

Applicant A

Applicant B

Signature

Signature

X _____

X _____

Signed at (City & State)

Date

Signed at (City & State)

Date

PART 11 PRODUCER/AGENT'S STATEMENT

	Applicant A	Applicant B
10a. Replacement: To the best of my knowledge, replacement of other insurance (check box) involved in this transaction.	<input type="checkbox"/> Is <input type="checkbox"/> Is Not	<input type="checkbox"/> Is <input type="checkbox"/> Is Not

Listed below are all other health insurance policies I have (i) sold to the Applicant(s) which are still in force; and (ii) sold to the Applicant(s) in the last five years which are no longer in force.

Applicant A/B	Company	Type of Policy	Effective Date	In-Force?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

	Applicant A	Applicant B
Please indicate the Underwriting Risk Classification quoted:	<input type="checkbox"/> Preferred	<input type="checkbox"/> Preferred
<i>Note: LTC Underwriting will determine the appropriate risk class regardless of that quoted to the applicant. We will communicate any change.</i>	<input type="checkbox"/> Select	<input type="checkbox"/> Select

I certify that I am duly licensed, appointed (when required), and have completed the required initial and ongoing training (where required) to solicit this application for long-term care insurance in this state.

Signature of Licensed Producer: _____

Producer Name (Please print): _____ Date: _____

Please attach the Illustration presented to the Applicant(s).

ADVANCED PAYMENT PROGRAM

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

Received: \$ _____

Applicant A Name: _____

Applicant B Name: _____

Requirements:

- You must make your advance payment by check, payable to 'John Hancock Life Insurance Company (U.S.A.)'. Do not make checks payable to the agent or leave the payee section blank.
- The advance payment must be equal to a minimum of one month's premium.
- Your check will be held in a non-interest bearing account while we underwrite your application.

Thank you for your advance premium payment. This section explains why an advance payment is so important to you.

By making an advance payment with this application, any change in your health status after the later of the following:

- i. the date of this Receipt, or
- ii. the date you complete any physical exams or tests required by us, will not affect the underwriting of your application.

This means that if you become ill, impaired or injured after the later of these dates, we will not consider such change in health in our underwriting process.

Please note that completing this application and making an advance payment does not guarantee that your application will be approved or that you will become insured.

If your application is approved, the long-term care insurance policy for which you applied will be issued to you. The effective date of your coverage will be stated in the policy issued and delivered to you. To keep your policy in force you must pay all the required premiums when due.

If your application is declined, the long-term care insurance coverage you applied for will not become effective, and any advance payment submitted with the application will be refunded to you immediately, without interest.

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

Agent Signature: _____

Date: _____

ADVANCED PAYMENT PROGRAM

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

Received: \$ _____

Applicant A Name: _____

Applicant B Name: _____

Requirements:

- You must make your advance payment by check, payable to 'John Hancock Life Insurance Company (U.S.A.)'. Do not make checks payable to the agent or leave the payee section blank.
- The advance payment must be equal to a minimum of one month's premium.
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By making an advance payment with this application, any change in your health status after the later of the following:

- i. the date of this Receipt, or
- ii. the date you complete any physical exams or tests required by us, will not affect the underwriting of your application.

This means that if you become ill, impaired or injured after the later of these dates, we will not consider such change in health in our underwriting process.

Please note that completing this application and making an advance payment does not guarantee that your application will be approved or that you will become insured.

If your application is approved, the long-term care insurance policy for which you applied will be issued to you. The effective date of your coverage will be stated in the policy issued and delivered to you. To keep your policy in force you must pay all the required premiums when due.

If your application is declined, the long-term care insurance coverage you applied for will not become effective, and any advance payment submitted with the application will be refunded to you immediately, without interest.

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

Agent Signature: _____

Date: _____

SERFF Tracking Number: MULF-127180705 State: Arkansas
 Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
 Company Tracking Number: CCIII MGSI APPLICATION
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Long-Term Care Insurance
 Project Name/Number: MGSI Application - CCIII/MGSI11 Application - CCIII

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	06/27/2011

Comments:

Attachment:

CERTIFICATION OF READABILITY6-15.pdf

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

Satisfied - Item: Application

Comments:

The application has been attached to the "Form Schedule" tab.

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

Bypassed - Item: Health - Actuarial Justification

Bypass Reason: Not applicable - no rates being filed.

Comments:

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

Bypassed - Item: Outline of Coverage

Bypass Reason: Please see previously approved SERFF filing #MULF-126977796, approved by your department on 2/23/2011.

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Accepted for Informational Purposes	06/27/2011

Comments:

SERFF Tracking Number: MULF-127180705 State: Arkansas
Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
Company Tracking Number: CCIII MGSI APPLICATION
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGSI Application - CCIII/MGSI11 Application - CCIII

Attachment:

AR MGSI Cover Letter.pdf

Item Status:

Status

Satisfied - Item: Statement of Variability

Approved-Closed

Date:

06/27/2011

Comments:

Attachment:

MGSI_Variability Statement.pdf

**CERTIFICATION OF READABILITY
State of Arkansas**

Application	LTC-MGSI11 AR	Flesch Score 46.2
Advance Payment Receipt	LTC-CR11 6/11	Flesch Score 54.2

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

6/15/2011
Date

Marie Roche, Assistant Vice President
Name and title of officer of the Issuer



Signature of officer of the Issuer

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

John Hancock Place
Post Office Box 111 B-6-6
Boston, Massachusetts 02117
1-888-877-6075
Fax: (617)450-8198
Email: phamlett@jhancock.com



Pat Hamlett
Contract Consultant
LTC Contracts and Legislative Services

May 24, 2011

Commissioner Jay Bradford
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: **John Hancock Life Insurance Company (U.S.A.)**
Company NAIC # 65838; FEIN #: 01-0233346
Individual Long-Term Care Insurance Submission
Application Form LTC-MGSI11 AR

Dear Commissioner:

We have enclosed the above referenced form for your review and approval. A description of this form is found below. This is a new application form to be used with our recently approved Custom Care III individual long-term care insurance policy form LTC-11 AR, approved by your department on 2/23/2011, SERFF# MULF-126977796. This application form LTC-MGSI11 AR is for use with our Sponsored Group Discount program for employers and associations.

Please note that we continue to upgrade our form production and issue system to a new technology. This upgrade may in some instances slightly alter the appearance of our forms based upon the new technology and the printers used. In addition, from time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/completed/printed via website technology. Variable information is enclosed by brackets “[]”. A statement of variability is attached.

This submission is being filed simultaneously with the Interstate Compact and remaining non-Compact states and the District of Columbia. We intend to implement this form once approved.

Please feel free to call me at 1-888-877-6075 or email me at phamlett@jhancock.com should you have any questions.

Thank you for your time and consideration in this matter.

Sincerely,

Pat Hamlett
Contract Consultant

Statement of Variability – Applications

Brackets [] indicate items that will be as shown or omitted.

Form LTC-MGSI11

Address may change if we move our administration offices.

1. Page 1, For Agent Use Only section may be removed entirely if not applicable to sales distribution channel.
2. Page 6, Questions 4n-4p
 - Questions may be removed entirely, if applicants are under age.
3. Page 8 – Part 5
 - Modified Standard Issue Program available benefits may vary based sales distribution channel, the benefits offered will at no time be less than the minimum standard.
 - Question 5a Benefit Amount
 - Either the Daily or Monthly benefit offer may be removed. At no time will the benefit offered be less than the minimum standard.
 - Question 5b Benefit Period
 - Benefit period may vary based on sales distribution channel, the benefit period offered will at no time be less than the minimum standard.
 - Question 5c Elimination Period
 - Some Elimination Periods may be removed based on the sales distribution channel.
 - Question 5d – Inflation Options
 - Inflation Option availability may vary based on sales distribution channel (variation by those displayed shown not any other options)
 - 5% Compound will always be offered.
 - Question 5e – Optional Benefits
 1. Optional benefit availability may vary based on sales distribution channel. (variation by those displayed shown not any other options).
 2. Nonforfeiture will always be offered.
4. Page 9 – Part 6
 - Question 6b
 1. Limited Payment Options availability may vary based on sales distribution channel. (variation by those displayed shown not any other options)
 - Question 6c
 1. Payment Method availability may vary based on sales distribution channel. (variation by those displayed shown not any other options)
5. Page 11 – Premium Agreement and Authorization
 - Statement #4
 1. Bracketed information will be removed for non-payroll deductions, list bill or employer pay plans that no advance payment is required.

SERFF Tracking Number: MULF-127180705 State: Arkansas
 Filing Company: John Hancock Life Insurance Company (USA) State Tracking Number: 48873
 Company Tracking Number: CCIII MGSII APPLICATION
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
 Product Name: Long-Term Care Insurance
 Project Name/Number: MGSII Application - CCIII/MGSII1 Application - CCIII

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)
05/23/2011		Supporting Flesch Certification Document	06/15/2011	CERTIFICATION OF READABILITY.pdf (Superseded)