

SERFF Tracking Number: MULF-128177503 State: Arkansas  
Filing Company: John Hancock Life & Health Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified  
Product Name: GLTC, new business rates, 2012  
Project Name/Number: GLTC, new business rates, 2012/GLTC, new business rates, 2012

## Filing at a Glance

Company: John Hancock Life & Health Insurance Company

Product Name: GLTC, new business rates, 2012 SERFF Tr Num: MULF-128177503 State: Arkansas

TOI: LTC03G Group Long Term Care

SERFF Status: Closed-Approved

State Tr Num:

Sub-TOI: LTC03G.001 Qualified

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Donna Lambert

Authors: Marie Roche, Noah Rice

Disposition Date: 07/06/2012

Date Submitted: 05/30/2012

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: GLTC, new business rates, 2012

Status of Filing in Domicile: Pending

Project Number: GLTC, new business rates, 2012

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust

Overall Rate Impact:

Filing Status Changed: 07/06/2012

State Status Changed: 07/06/2012

Deemer Date:

Created By: Noah Rice

Submitted By: Noah Rice

Corresponding Filing Tracking Number:

Filing Description:

We have enclosed copies of the forms referenced in Appendix A of our cover letter, for your review and approval. We are submitting a policy face page, and certificate face page. We are submitting applications, to reflect our new underwriting standards. We have also modified our rate guarantee language, and therefore we are submitting new forms reflecting that language under the forms schedule, as well as corresponding rates. We have added language to the Schedule of Benefits and Master Schedule to further clarify the changes to the Rate Guarantee. All other forms remain unchanged from our 2009 filing, P-FACE(2009), et al.

State Narrative:

## Company and Contact

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**Filing Contact Information**

Noah Rice, Sr. Contract Consultant nrice@jhancock.com  
 200 Berkeley Street 617-572-4027 [Phone]  
 Boston, MA 02117

**Filing Company Information**

John Hancock Life & Health Insurance CoCode: 93610 State of Domicile: Massachusetts  
 Company  
 200 Berkeley Street Group Code: 904 Company Type: Life & Health  
 Boston, MA 02117 Group Name: State ID Number:  
 (617) 572-6000 ext. [Phone] FEIN Number: 13-3072894

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$450.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form x 8 forms = \$400  
 \$50 per rate x 1 set of rates = \$50  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life & Health Insurance Company	\$450.00	05/30/2012	59510666

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	07/06/2012	07/06/2012

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	06/11/2012	06/11/2012	Noah Rice	07/05/2012	07/05/2012
Pending Industry Response	Donna Lambert	06/06/2012	06/06/2012	Noah Rice	06/06/2012	06/06/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
SERFF Tracking Number for previously approved forms	Note To Reviewer	Noah Rice	06/06/2012	06/06/2012
SERFF TRACKING NUMBER FOR APPROVED FORMS	Note To Filer	Donna Lambert	06/06/2012	06/06/2012

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## Disposition

Disposition Date: 07/06/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
John Hancock Life & Health Insurance Company	%	%	\$		\$	%	%

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	No
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Supporting Document</b>	Cover Letter	Approved	Yes
<b>Form</b>	Policy Face Page	Approved	Yes
<b>Form</b>	Master Schedule	Approved	Yes
<b>Form</b>	Policy Premiums	Approved	Yes
<b>Form</b>	Certificate Face Page	Approved	Yes
<b>Form</b>	Certificate Schedule of Benefits	Approved	Yes
<b>Form</b>	Premiums	Approved	Yes
<b>Form</b>	Full Underwriting application	Approved	Yes
<b>Form</b>	Streamline Underwriting application	Approved	Yes
<b>Rate</b>	rates from actuarial memorandum	Approved	Yes

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/11/2012
Submitted Date	06/11/2012
Respond By Date	07/11/2012

Dear Noah Rice,

We have one objection to this filing.

### Objection 1

- Policy Premiums, P-PREM(2009-12) (Form)

Comment: We disagree with the statement that the grace period begins with the premium due date. The grace period should begin the day after the premium due date. Please revise this sentence.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 07/05/2012  
Submitted Date 07/05/2012

Dear Donna Lambert,

### Comments:

#### Response 1

Comments: It is our position that our grace period exceeds the 30 day requirement under Arkansas state law, by one day. Therefore, we respectfully request to maintain our existing grace period (of 31 days), as originally submitted. This is a national filing, and every modification has impacts on our contract generation system. Our existing grace period meets the requirements of Arkansas law, even if one day is subtracted from the total of 31 days (30 days if measured from day after premium is due).

We thank you for your continued review of this filing.

Sincerely,

Noah Rice

#### Related Objection 1

Applies To:

- Policy Premiums, P-PREM(2009-12) (Form)

Comment:

We disagree with the statement that the grace period begins with the premium due date. The grace period should begin the day after the premium due date. Please revise this sentence.

#### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

SERFF Tracking Number: MULF-128177503 State: Arkansas

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Sincerely,

Marie Roche, Noah Rice

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/06/2012
Submitted Date	06/06/2012
Respond By Date	07/06/2012

Dear Noah Rice,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Cover Letter (Supporting Document)

Comment: Are all of the submitted forms new? If any of the forms are revised, previously-approved forms, they must have an updated form number.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/06/2012  
Submitted Date 06/06/2012

Dear Donna Lambert,

### Comments:

### Response 1

Comments: Ms. Lambert,

All submitted forms are new. They are similar to some previously approved forms, but they all have new form numbers as part of the new policy series, P-FACE(2009-12). Some previously approved forms will be used with the submitted forms, but those forms will not be changed in any way.

I hope that answers your question. Thanks you for your continued review.

Sincerely,  
Noah Rice

### Related Objection 1

Applies To:

- Cover Letter (Supporting Document)

Comment:

Are all of the submitted forms new? If any of the forms are revised, previously-approved forms, they must have an updated form number.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

*SERFF Tracking Number:* MULF-128177503 *State:* Arkansas

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Sincerely,

Marie Roche, Noah Rice

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**Note To Reviewer**

**Created By:**

Noah Rice on 06/06/2012 03:19 PM

**Last Edited By:**

Donna Lambert

**Submitted On:**

07/06/2012 02:33 PM

**Subject:**

SERFF Tracking Number for previously approved forms

**Comments:**

MULF-125634076

SERFF Tracking Number: MULF-128177503 State: Arkansas  
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**Note To Filer**

**Created By:**

Donna Lambert on 06/06/2012 02:24 PM

**Last Edited By:**

Donna Lambert

**Submitted On:**

07/06/2012 02:33 PM

**Subject:**

SERFF TRACKING NUMBER FOR APPROVED FORMS

**Comments:**

Please provide the SERFF Tracking # for the previously approved forms.

SERFF Tracking Number: MULF-128177503 State: Arkansas  
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## Form Schedule

### Lead Form Number: P-FACE(2009-12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 07/06/2012	P- FACE(2009-12)	Policy/Cont ract/Fratern al	Policy Face Page	Initial		0.000	P- FACE(2009-12).pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved 07/06/2012	P- MS(2009-12)	Policy/Cont ract/Fratern al	Master Schedule	Initial		0.000	P-MS(2009-12).pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved 07/06/2012	P- PREM(2009-12)	Policy/Cont ract/Fratern al	Policy Premiums	Initial		0.000	P- PREM(2009-12).pdf
		Certificate: Amendmen t, Insert Page, Endorseme nt or Rider					
Approved 07/06/2012	C- FACE(2009-12)	Certificate	Certificate Face Page	Initial		0.000	C- FACE(2009-12).pdf
Approved	C-	Certificate	Certificate Schedule	Initial		0.000	C-SOB(2009-

<i>SERFF Tracking Number:</i>	<i>MULF-128177503</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>John Hancock Life &amp; Health Insurance Company</i>		
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>LTC03G Group Long Term Care</i>	<i>Sub-TOI:</i>	<i>LTC03G.001 Qualified</i>
<i>Product Name:</i>	<i>GLTC, new business rates, 2012</i>		
<i>Project Name/Number:</i>	<i>GLTC, new business rates, 2012/GLTC, new business rates, 2012</i>		
07/06/2012	SOB(2009- 12)	of Benefits	12).pdf
Approved	D-	Certificate Premiums	Initial
07/06/2012	PREM(2009- 9-12)		0.000
Approved	GLTC-	Application/ Full Underwriting	Initial
07/06/2012	APP-	Enrollment application	0.000
	STD(2009- 12)	Form	GLTC_APP_ STD(2009- 12).pdf
Approved	GLTC-	Application/ Streamline	Initial
07/06/2012	APP-	Enrollment Underwriting	0.000
	STREAM(2 009-12)	Form application	GLTC_APP_ STREAM(200 9-12).pdf



**JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY**  
**(John Hancock)**

John Hancock agrees with the Policyholder to pay the benefits and provide the other rights set forth in the Policy. Such agreement is subject to all conditions and provisions of the Policy.

**Policy Number:** {26995-LTC}  
**Policy Effective Date:** {January 1, 2009}  
**Policyholder:** {ABC Corporation}  
**Jurisdiction of Issue:** {Massachusetts}  
**Policy Anniversaries:** {January 1 of 2009} and of each succeeding year.  
**Premium Due Dates:** {The Policy Effective Date; and the first day of each succeeding month.}

**JOHN HANCOCK LIFE & HEALTH INSURANCE COMPANY** (John Hancock) agrees to pay the benefits in accordance with all provisions set forth in the Policy. The Policy is issued to the Policyholder in consideration of its application and its payment of premium to John Hancock.

The Policy is delivered in the Jurisdiction of Issue shown above. It is subject to the laws of that jurisdiction.

For the purposes of effective dates under the Policy, all days begin at 12:01 AM Eastern Time.

Along with applications, the provisions on the following pages and in amendments, riders and exhibits included at issue or added thereafter are part of the Policy.

Signed by the officers of the {John Hancock Life & Health Insurance Company at Our service office at 197 Clarendon Street, Boston, Massachusetts 02117 Tel. (617) 572-6000.}

Secretary

President

**[GROUP LONG-TERM CARE INSURANCE POLICY]**

**[GROUP NURSING HOME/ALTERNATE CARE FACILITY ONLY INSURANCE POLICY]**

**The Policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**

**Master Schedule  
"Schedule"**

**John Hancock Group Policy No. {1234567} issued to**

**{ABC Corporation}  
(Policyholder)**

**Eligible Class {1}:**        {The Eligible Class consists of:

- Active Employees
- Retired Employees and
- Directors and
- Active Members and
- Qualifying Dependents}

{Retired Employees, Directors, and Qualifying Dependents other than Spouses and Domestic Partners of Active Employees must reside in the United States on their Initial Coverage Effective Date. Active Employees and Active Members and their Spouses and Domestic Partners who apply while residing outside the United States must provide their U. S. residence address.}

{[Insured Persons who are continuing their coverage may also be eligible to apply.]}

**Waiting Period:**        {30 Days}

{The Waiting Period is a period of active full-time employment employees must complete with the Employer before becoming eligible for insurance. Eligible employees must complete the Waiting Period before they and their Qualifying Dependents may apply for insurance under the Policy.}

**Policy Effective Date:**   {1/1/2009}

**[Policy Revision Date:   {6/1/2009} ]**

**Maximum Benefit Factor:**   {730}

**Qualification Period:**    {90 days}

**Premium Rate Guarantee Period:** {60 months from the Policy Effective Date, for an Insured Person's Initial Coverage}

{Eligible class members select from the following Nursing Home Daily Maximum Benefits. Other daily amounts are set as percentages of that amount.} We will pay the daily charges incurred for Covered Services, up to the maximum amounts selected and subject to all the terms and conditions of the Policy.

	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>
<b>Nursing Home Daily Maximum Benefit</b>	{ \$70	\$140	\$210
<b>Alternate Care Facility Daily Maximum Benefit</b>	\$35	\$105	\$157.50

**Master Schedule  
"Schedule"**

<b>[Home and Community Professional Care Daily Maximum Benefit</b>	\$35	\$70	\$105}]
<b>[Home and Community Professional Care Monthly Maximum Benefit</b>	{\$1,050	\$2,100	\$3,150]
<b>[Home and Community Based Care Daily Maximum Benefit</b>	\$35	\$70	\$105
<b>[Home and Community Based Care Monthly Maximum Benefit</b>	\$1,050	\$2,100	\$3,150]
<b>[Informal Care Daily Maximum Benefit</b>	\$17.50	\$35	\$52.50]
<b>Calendar Year Maximum for Informal Care<sup>1</sup></b>	\$367.50	\$735	\$1,102.50]
<b>Lifetime Maximum Benefit <sup>2</sup></b>	\$51,100	\$102,200	\$153,300
<b>[Stay At Home Lifetime <sup>3</sup> Benefit Amount</b>	\$2,100	\$4,200	\$6,300]
<b>[Monthly Cash Benefit Amount <sup>4</sup></b>	\$105	\$210	\$315}]

---

<sup>1</sup> [This amount is determined by multiplying {30} by the Informal Care DMB].

<sup>2</sup> This amount is determined by multiplying the Nursing Home Daily Maximum Benefit by the Maximum Benefit Factor.

<sup>3</sup> [This amount is determined by multiplying 30 by the Nursing Home Daily Maximum Benefit.]

<sup>4</sup> [This amount is determined by multiplying {3} {6} by the Home and Community Professional Care/Home and Community Based Care Daily Maximum Benefit or {10%} {20%} times the Home and Community Professional Care/Home and Community Based Care Monthly Maximum Benefit. ]

## Premiums

### Premium Payment

The initial premium is due and payable on or before the Policy Effective Date unless otherwise agreed to in writing by Us. Each premium is payable in advance of its due date. Premiums are payable in U. S. currency only. Payment shall be made by check, wire transfer, automatic bank deduction or other methods approved by Us. Payment shall be made only to John Hancock Life & Health Insurance Company; it shall be sent directly to the address requested by Us.

No person or entity may accept any premium payment on Our behalf, without express, specific and valid written authorization by Us to do so. Payment of any premium to a person or entity not so authorized shall not discharge the obligation of the Policyholder to pay to Us the amount of such premium.

Except as provided under **Grace Period** below, payment of any premium shall not keep insurance under the Policy in force beyond the day before the day the next such premium is due.

### Premium for Changes in Insurance

Premium is charged for insurance beginning on the day the insurance becomes effective.

[Premium collection by the policyholder for insurance that ends during a calendar month will cease at the end of that calendar month. Premium amounts owed or to be credited for the first premium or for insurance additions, increases or terminations, will be payable when We determine the appropriate amount.]

[If premiums are payable on other than a monthly basis, premium charges or credits for a part of a premium-paying period will be made on a pro rata basis for the number of whole months in the period which:

- in the case of premium charges, starts on the date the charges begin, or
- in the case of premium credits, starts on the day after premium charges cease, and
- in either case, ends when the premium-paying period ends.]

### Grace Period

If any premium, after the first premium, for which the Policyholder is responsible for collecting through payroll {or pension deduction,} is not paid by the Policyholder on or prior to its due date, a grace period shall be granted for the payment of that premium without a late charge. But, the grace period will not be granted if on or prior to such date the Policyholder has given Us written notice the Policy is to terminate. The grace period begins with the premium due date. It lasts for {thirty-one (31)} days, unless ended on an earlier date which the Policyholder may specify in a written notice to Us during the grace period.

If the grace period lasts for {thirty-one (31)} days it will be extended [until the end of the calendar month after the calendar month in which the grace period began]. Such extension will not occur if either party has given written notice to the other during the {thirty-one (31)} day period that the grace period is not to last more than {thirty-one (31)} days.

## Premiums

If the grace period is to be ended by written notice, the date it ends will not be earlier than the date either party receives the notice. Notice to Us must be received at Our service office.

If premium is not paid on or before the {35<sup>th</sup>} day after it is due, We reserve the right to apply an interest charge at the prevailing rate We charge other group policyholders for the time it remains unpaid after that day.

If premium that the Policyholder is responsible for collecting through payroll [or pension] deduction is not paid by the end of the grace period, the Policy will terminate at the end of the grace period.

With respect to any premium that the Policyholder is responsible for collecting through payroll [or pension] deduction, the Policyholder will be liable to Us for:

- premium for the days the Policy is in force; and
- accrued late charges.

### Right To Change Premium Rates

We may change premium rates for any or all coverages as of the first day of a month. However, We will not change a rate for an Insured Person's Initial Coverage, to be effective before the end of the Premium Rate Guarantee Period shown on the Master Schedule.

Notice of a new premium rate will be given to the Policyholder not less than {sixty (60)} days before the date the new rates become effective.

### Insurance Cost Basis

{The Employer may elect:

- that the entire cost of the insurance be payable by the Insured Person;
- that the Insured Person contribute to the cost of his or her insurance; or
- that no contribution to the cost of insurance be made by the Insured Person. }

## Premiums

### Premium Calculations

Premium due to John Hancock on any premium due date shall be equal to the sum of premium contributions for insurance on each Insured Person. The individual {monthly} premium contributions for each Insured Person shall be as determined from the schedules on the following pages.

### Schedule of {Monthly} Premium Charges for Long-Term Care Insurance

[

]



[GROUP LONG-TERM CARE INSURANCE]  
[GROUP NURSING HOME/ALTERNATE CARE FACILITY ONLY INSURANCE]

underwritten by  
**John Hancock Life & Health Insurance Company**  
Boston, Massachusetts  
**(John Hancock)**

for

[ABC Corporation]  
**(Policyholder)**

The Schedule of Benefits (referred to as Schedule) shows the policy number of the group policy, called "the Policy", under which Your insurance is provided. If You become insured under the Policy, this document, with Your Schedule:

- becomes Your Certificate of Insurance (Certificate); and
- supersedes any prior Certificates issued to You under the Policy.

\*\*\*\*\*

**RIGHT TO RETURN THIS CERTIFICATE WITHIN 30 DAYS**

If You are not satisfied with the coverage provided, You may return this Certificate within 30 days of the date it was delivered to You. Mail or deliver the Certificate to Our service office at:

John Hancock Life & Health Insurance Company  
{P. O. Box 111  
Boston, MA 02117  
Attention: Group Long-Term Care Division B-6}

We will then refund any premium paid. The Certificate will be treated as if it had never been issued.

**Caution:** If You were required to answer health questions in applying for this insurance, issuance of this Certificate is based upon Your responses to the questions on Your application. A copy of Your application is provided. If Your answers are incorrect, incomplete or untrue, We may have the right to deny benefits or rescind Your insurance. The best time to clear up any questions is now, before a claim arises. If, for any reason, any answer is incorrect, contact Us at the address shown above.

**Notice to Buyer:** This Certificate may not cover all the costs associated with long-term care incurred by the buyer during the period of coverage. You are advised to review carefully all limitations and exclusions.

**FEDERAL INCOME TAX TREATMENT OF THIS INSURANCE**

**This insurance is intended to be qualified long-term care insurance under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.**

{Subject to specified dollar amounts that vary depending on Your age, You may be able to include Your premium in Your itemized deductions on Your Federal income tax return, if Your total medical expenses, including the allowable portion of Your premium, exceed {7½%} of adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. Please remember that tax laws can change and to consult Your tax advisor if You have any questions or need further details.}

**Guaranteed Renewable:** This insurance is guaranteed renewable. This means that You have the right to continue Your coverage in force by paying the required premium when due. If the Policy terminates, You may continue Your coverage under a replacement policy or under continued coverage as provided in **Continuation Coverage**. We reserve the right to increase Your premiums in the future. However, any change in premium rates will apply to all insureds in the same group or class. We may not unilaterally change Your coverage. Changes in coverage can only be made in accordance with the provisions of the Policy.

John Hancock certifies that the insurance described in this document is available to persons in the Eligible Class. You will find the Eligible Class on the Schedule of Benefits.

The Policy is the contract of insurance between the Policyholder and John Hancock; it controls all the terms and conditions of Your insurance. The terms and conditions of the Policy are not waived by anything contained in this document.

If You have any complaints regarding this insurance, You may contact {the Vice President of GLTC Operations at Our address shown above.}

**Schedule of Benefits  
"Schedule"**

**John Hancock Group Policy No. {1234567} issued to**

**{Policyholder}**

[Mr. Joe Sample]	Issue Age for Initial Coverage: [45]
[Any Street]	Policy Issue State: [XX]
[Somewhere, USA 12345]	Certificate Issue State: [XX]
	Initial Coverage Effective Date <sup>1</sup> : [January 1, 2009]
	Effective Date of This Schedule of Benefits <sup>2</sup> : [January 1, 2009]
	Current Monthly Premium: [\$99.99]

**Optional Benefits Selected**

[Reduced Lifetime Maximum Benefit - Nonforfeiture Benefit]	Yes	No]
[Return of Premium At Death]	Yes	No]
[Automatic Benefit Increase]	Yes	No]
[Automatic Consumer Price Index (ACPI) Benefit Increase]	Yes	No]
[Shared Care Benefit]	Yes	No]
[Accelerated Payment Option]	Yes	No]
[10-Year Payment Option]	Yes	No]
[Secondary Insured:		[Joe Sample] ]
[Shared Care Reserved Amount:		[\$ Amount] ]

We will pay the covered charges You incur for Covered Services, up to the maximum amounts shown below and subject to all the terms and conditions of Your Certificate.

<b>Benefit</b>	<b><u>Maximum Amount</u></b>
Nursing Home Daily Maximum Benefit	{\$70
Alternate Care Facility Daily Maximum Benefit	\$52.50
[Home and Community Professional Care Daily Maximum Benefit	\$35
Home and Community Professional Care Monthly Maximum Benefit	\$1050
Home and Community Based Care Daily Maximum Benefit	\$35
Home and Community Based Care Monthly Maximum Benefit]	\$1,050
[Informal Care Daily Maximum Benefit	\$17.50
Calendar Year Maximum for Informal Care <sup>3</sup> ]	\$525
Lifetime Maximum Benefit	\$52,100
[Stay-At-Home Lifetime Benefit Amount <sup>4</sup>	\$2,100
Monthly Cash Benefit Amount <sup>5</sup> ]	\$105}

<sup>1</sup> Subject to Effective Date Postponement provisions that could, if applicable, delay the Effective Date of Coverage.

<sup>2</sup> This Schedule replaces any prior version unless You are subject to the Effective Date Postponement provision.

<sup>3</sup> [This amount is determined by multiplying {30} by the Informal Care Daily Maximum Benefit.]

<sup>4</sup> [This amount is determined by multiplying 30 by the Nursing Home Daily Maximum Benefit.]

<sup>5</sup> [This amount is determined by multiplying {3} {6} by the Home and Community Professional Care/Home and Community Based Care Daily Maximum Benefit or {10%} {20%} times the Home and Community Professional Care/Home and Community Based Care Monthly Maximum Benefit. ]

**Schedule of Benefits  
“Schedule”**

**Eligible Class:** {The Eligible Class consists of:

- Active Employees
- Retired Employees and
- Directors and
- Active Members and
- Qualifying Dependents}

{Retired Employees, Directors, and Qualifying Dependents other than Spouses and Domestic Partners of Active Employees or Active Members must reside in the United States on their Initial Coverage Effective Date. Active Employees and Active Members and their Spouses and Domestic Partners who apply while residing outside the United States must provide their U. S. residence address.}

[[Insured Persons who are continuing their coverage may also be eligible to apply.]]

**Waiting Period:** {30 Days}

{The Waiting Period is a period of active full-time employment employees must complete with the Employer before becoming eligible for insurance. Once eligible employees complete the Waiting Period, they and their Qualifying Dependents may apply for insurance under the Policy.}

**Policy Effective Date:** {1/1/2009}

**Maximum Benefit Factor:** {730}

**Qualification Period:** {90 days}

**{Premium Rate Guarantee Period:** 60 months from the Policy Effective Date, for an Insured Person's Initial Coverage}

If Your insurance ends for any reason, see the Termination of Coverage section to learn what options are available for continued coverage of benefits upon termination of the Policy or Your individual coverage under the Policy.

[Effective MO/DD/YR, this Schedule replaces any prior version unless You are subject to the Effective Date Postponements provision.]

**Call Us for assistance with Your care needs. Early notification to Our Claims Department will facilitate timely qualification for benefits and review of Your claim. Please let Us know immediately or in advance, whenever possible. Please call {1-XXX-XXX-XXXX} for assistance. {TTY 1-800-255-1808} for hearing impaired. Outside the United States call {1-617-572-0048}.**

## Premiums

### Payment of Premiums

#### ***[By Payroll[ or {Pension Deduction}]***

Premium contributions for Active Employees[at specified locations] [or Active Member] [ and their Spouses ] [or Domestic Partners] will be collected by the Employer through payroll deduction. [Premium contributions for Retirees and their Spouses [or Domestic Partners] will be collected by {the Employer through pension deduction}. or Retirees may elect to have premium contributions for themselves and their Spouses[or Domestic Partners] collected by {the Employer through pension deduction}. ]

#### ***Directly Billed***

[Retired employees and] All [other] Insured Persons [will][may elect to] be billed directly, or Insured Persons may authorize automatic deduction of the monthly required premium contribution {from the Insured Person's checking account}.

Premium payment is due and payable on the first day of each month. It must be paid in United States currency. You may cancel Your coverage at any time. If You die or cancel Your coverage, We will return unearned collected premium.

#### **Grace Period for Directly Billed Individuals**

A 31-day Grace Period applies to Your individual coverage if You are directly billed. If premium is not paid within thirty-one (31) days from the date that it is due, We will provide written notification of the nonpayment of the premium to You and any person or persons You designate to receive such notice. After We have mailed this notice, You have an additional 35-day period to pay the premium. During the extended Grace Period, Your coverage will stay in effect. If We do not receive the premium payment before the end of the extended Grace Period, Your coverage will terminate.

#### **Right to Change Premium Rates**

We cannot change Your premiums because of age or health. However, We can change premiums for all Insured Persons in the same group or premium class. A change may be made, as provided in the following paragraph.

We may change premium rates under the Policy as of the first day of the calendar month. We will not change premium rates for Your Initial Coverage before the end of the Premium Rate Guarantee Period. Your Initial Coverage is the coverage in effect as of Your Initial Coverage Effective Date, and does not include any inflation increases or coverage additions effective after the Initial Coverage Effective Date. If We set new premium rates[:

- We will notify the Policyholder at least {sixty (60)} days before the date the new rates become effective; and
- if You are paying premiums directly to Us, ] We will notify You at least {sixty (60)} days before the date new rates that affect Your existing coverage become effective. [Either We or the Policyholder will notify You directly of such change if Your premiums are paid by payroll or pension deduction.]

## Premiums

The Premium Rate Guarantee Period does not limit Our right to terminate or discontinue enrollments under the Policy.

### **[Ten-Year Payment Option]**

[Ten-Year Premium Payment applies to You if You selected it on Your application and it is shown on Your Schedule.

This means that Your coverage under Your Certificate is fully paid-up and no further premiums will be due on or after the tenth anniversary of Your Initial Coverage Effective Date, provided You have paid all premiums due.

Any period for which premium has been waived under the Waiver of Premium provision will count toward the required ten (10) years.

Nothing herein affects Our rights under the Right to Change Premiums provision during the ten years before Your coverage under Your Certificate is fully paid-up.]

### **[Accelerated Payment Option]**

[The Accelerated Payment Option applies to You if You selected it on Your application and it is shown on Your Schedule.

This means that Your coverage under Your Certificate is fully paid-up and no further premiums will be due on the later of:

- the tenth anniversary of Your Initial Coverage Effective Date; or
- the first anniversary of Your Initial Coverage Effective Date following Your 65<sup>th</sup> birthday.

Prior to the time Your coverage becomes fully paid-up, You must make sure that You pay the premiums when they are due to continue coverage under Your Certificate.

Any period for which premium has been waived under the Waiver of Premium provision will count toward the required ten (10) years.

Nothing herein affects Our rights under the Right to Change Premiums provision during the period before Your coverage under Your Certificate is fully paid-up.]

### **[Reduced Paid-Up Contingent Nonforfeiture Benefit For Ten-Year or Accelerated Payment Option]**

In addition to any Nonforfeiture or Contingent Nonforfeiture Benefit that may be available to You under the Policy, You are eligible for the Reduced Paid-Up Contingent Nonforfeiture Benefit when all of the following requirements are met:

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

## Premiums

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

- You lapse (stop paying your premiums) within 120 days of the date the premium increase took effect; and
- The ratio of the number of completed months You already paid premiums is 40% or more than the number of months You originally agreed to pay.

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

- Your new remaining Lifetime Benefit Maximum for Your reduced paid-up coverage will be determined by multiplying 90% of the remaining Lifetime Benefit Maximum at the time coverage lapsed by the ratio of the number of completed months of paid premiums to the number of months you agreed to pay them.
- Your {daily, monthly and calendar year} benefit amounts will also be adjusted by the same ratio.

No benefits will be paid in excess of any benefit limit(s) that would have been paid if You had continued to pay premiums as required. [In addition, if You purchased lifetime benefits, only the {daily, monthly and calendar year} benefit amounts will be adjusted by the applicable ratio. ]

### **No Increases**

On and after the date Your reduced paid-up coverage takes effect, You will not be eligible for any benefit increases, including any Inflation Additions. [If your coverage is in a reduced paid-up status [Shared Care,] [Restoration of Benefits,] [Monthly Cash Benefit,] and [the Stay-At-Home Benefit are not available. ]

If You are eligible for the Reduced Paid-Up Contingent Nonforfeiture Benefit and another nonforfeiture benefit under the Policy, You may choose between either of the two benefits.]

# APPLICATION FOR INSURANCE UNDER [THE ABC COMPANY] GROUP LONG-TERM CARE INSURANCE PLAN

Underwritten by John Hancock Life & Health Insurance Company (John Hancock), Boston, MA 02117

Group Number: {XXX}  
Form A

## Instructions for first-time applicants

1. [If you are:
  - An eligible, actively-at-work {employee} [enrolling/applying] during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - A newly hired eligible or newly eligible, actively-at-work {employee} [enrolling/applying] within {XX} days of first becoming eligible; or
  - An {employee} who was on a leave of absence or disability during the designated {XXXX} enrollment period [enrolling/applying] within {XX} days of returning to work on a regular basis;]please complete and submit the enclosed [**Employee Enrollment Form for Automatic Acceptance or Streamlined Application,**] [unless you are issue age 70 or older] [or] [you are choosing the {\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].
- [2]. [If you are the spouse[ or domestic partner] [or other family member] of an eligible, actively-at-work {employee} applying during the {employee's} [automatic acceptance] enrollment period [as described in Item 1 above] or within {XX} days of first becoming eligible, [and you **are not** choosing the {\$XXX DMB or {10-year/20-year/Unlimited} LMB or Shared Care Benefit] [and you are not issue age 70 or older,] please complete and submit the enclosed **Streamlined Application.**]
- [3]. [If you are [an eligible, actively-at-work {employee} issue age 70 or older, or you are] choosing the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], please fill in all sections of this application.  
**Please note:** If you are an actively-at-work {employee} in a group as described in Item 1 above, and you are declined for the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], you will be automatically enrolled into the plan at the next highest [DMB] [and/or] [LMB] available[, as long-as you answer "NO" to every question in Section 1 below]. [If you are a [spouse[ or domestic partner] or other family member] as described in Item 2 above, and you are declined for the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], you will be automatically enrolled into the plan at the next highest [DMB] [and/or] [LMB] available, as long-as you answer "NO" to every question in Section 1 below.]
- [4]. [If you are choosing the Shared Care Benefit, please fill in all sections of this application. You and your spouse[ or domestic partner] must each complete an application; choose all of the same benefit options [(e.g.: Daily Maximum Benefit (DMB), Lifetime Maximum Benefit (LMB), Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit), and Inflation Provision)]; **and submit your applications together.**  
**Please note:** If you are an actively-at-work {employee} in a group as described in Item 1 above, and you or your spouse[ or domestic partner] is declined for coverage, you will be automatically enrolled into the plan with the coverage you choose on this application (without the Shared Care Benefit)[, as long-as you answer "NO" to every question in Section 1 below]. [If you are a [spouse[ or domestic partner]] as described in Item 2 above, and you or the actively-at-work employee is declined for coverage, you will be automatically enrolled into the plan with the coverage you choose on this application (without the Shared Care Benefit), as long-as you answer "NO" to every question in Section 1 below.]
- [5]. All [other] first-time applicants must complete their own application and fill in all sections. An application that is not completed properly will cause a delay in processing by John Hancock.

## Instructions for currently insured applicants who want to change coverage[\*]

### [(If 1 plan design)

1. If you would like to **increase** your coverage, please fill in all sections of this application. An increase in coverage can be the purchase of a higher Daily Maximum Benefit (DMB)[, higher Lifetime Maximum Benefit (LMB) or adding an optional benefit].  
**[Please note:** If you wish to choose the Shared Care Benefit, please refer to Item {4} above.]
2. If you would like to **decrease** your coverage, please fill in Sections 2, 3 and 5 (Agreement & Acknowledgement) only. A decrease in coverage can be choosing a lower DMB [or LMB or removing an optional benefit from your coverage].
3. If you would like to do both (increase a portion of your coverage and decrease another), please fill in all sections.

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]]

### [(OR if 2+ plan designs – ongoing upgrades)

1. If you have coverage under the group long-term care insurance plan originally offered by {ABC Company} insured through John Hancock and would like to:
  - replace that coverage with this newly offered coverage, please fill in all sections of this application. If you are approved for this coverage, you will relinquish all rights and benefits of your current coverage for the rights and benefits of your new coverage.
  - make changes to your current coverage (and not apply for this newly offered coverage), please call John Hancock at {1-800-xxx-xxxx} for your application.
2. If you already have coverage under this newly offered group long-term care insurance plan insured through John Hancock and would like to:
  - increase your coverage (e.g., purchase a higher Daily Maximum Benefit (DMB) [or add an optional benefit]), please fill in all sections.
  - decrease your coverage (e.g., choosing a lower DMB), please fill in Sections 2, 3 and 5 (Agreement & Acknowledgement) only.
  - do both (increase a portion of your coverage and decrease another), please fill in all sections.

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[\*Please note: If you want to **keep** your current coverage under the plan originally offered by {ABC Company} insured through John Hancock **and apply** for this newly offered coverage, please fill in all sections.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

## Instructions for applicants who want to reinstate coverage

If you have already contacted John Hancock regarding your reinstatement of coverage and would like to apply, please fill in all sections of this application.

**Please sign and date the application where indicated. Return in the enclosed postage-paid envelope to John Hancock Service Office:**

**John Hancock Life & Health Insurance Company, {Group Long-Term Care Department, B-6,  
John Hancock Place, P.O. Box 111, Boston, Massachusetts 02117-9939}**

*{If you are a resident of {XX}, please call 1-800-XXX-XXXX for your application.}*

{If you have any questions or would like more applications, please call the John Hancock Long-Term Care Customer Service Center toll-free at **1-800-XXX-XXXX**. Outside the United States, the number is {(617) 572-0048}. The TTY number for the hearing impaired is 1-800-255-1808. You can also visit our Long-Term Care Web site at [www.jhancock.com/gltc](http://www.jhancock.com/gltc), or email us at [gltc@jhancock.com](mailto:gltc@jhancock.com).}

**Please note:** You must meet all eligibility requirements (as described in the Plan Summary) in order for this coverage to go into effect.

**{ABC Company} – Group Number {XXX}**

## SECTION 1: ANSWER THESE QUESTIONS FIRST

**Please check "YES" or "NO" beside each question:**

**1. Within the past 7 years, have you received: medical advice; diagnosis; or treatment from a member of the medical profession for:**

- Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or Human Immunodeficiency Virus (HIV)
- Alzheimer's Disease, Cognitive Impairment, Dementia, or Memory Loss ■ Amyotrophic Lateral Sclerosis ■ Cerebral Atrophy
- Cirrhosis ■ Crest ■ Cystic Fibrosis ■ Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney
- Huntington's Chorea ■ Kidney Disease ■ Mental Retardation ■ Metastatic Cancer ■ Mixed Connective Tissue Disease
- Multiple Myeloma ■ Multiple Sclerosis ■ Possible Multiple Sclerosis ■ Muscular Dystrophy ■ Myasthenia Gravis
- Neurological conditions affecting the brain or spinal cord ■ Parkinson's Disease ■ Polyneuropathy ■ Post-Polio Paralytic Syndrome
- Schizophrenia ■ Scleroderma ■ Spinal Cord Injury ■ Stroke/CVA ■ Systemic Lupus Erythematosus
- Transient Ischemic Attacks (2 or more)?.....

**Yes No**

**2. Do you require human assistance or supervision in any of the following activities:**

- eating ■ dressing ■ toileting ■ transferring from bed to chair ■ walking ■ maintaining continence ■ bathing?.....

**3. Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home; assisted care living facility or other custodial facility; or are you currently receiving home health care services or attending adult day care? .....**

**4. Do you currently use any of the following medical devices:**

- wheelchair ■ walker ■ hospital bed ■ quad cane ■ oxygen ■ stairlift ■ dialysis?.....

**5. Are you currently receiving Social Security Disability; Worker's Compensation; or Long-Term Disability Benefits? .....**



**If you answered "YES" to any of questions 1 – 5 above, we suggest that you do not submit an application; we will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue. [Please note: John Hancock's final underwriting decision will be based on a full underwriting evaluation of your medical history.]**

**[\$XXX DMB] [and/or] [(10-year/20-year/Unlimited) LMB] Applicants Please Note:** If you are an actively-at-work {employee} [of ABC Company] in a group as described in Item 1 of the "Instructions," and you answered "YES" to any of questions 1 – 5 above, you are eligible to receive automatic acceptance into the plan **with a lower [DMB] [and] [LMB] amount.** Please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance.**

**[Shared Care Benefit Applicants Please Note:** If you are an actively-at-work {employee} [of ABC Company] in a group as described in Item 1 of the "Instructions," and you answered "YES" to any of questions 1 – 5 above, you are eligible to receive automatic acceptance into the plan **without the Shared Care Benefit.** Please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance.** [If you are the spouse[ or domestic partner] as described in Item 2 of the "Instructions," and the actively-at-work employee answered "YES" to any of questions 1 – 5 above, you are eligible to receive streamlined underwriting into the plan **without the Shared Care Benefit.** Please complete and submit the enclosed **Application B.**]

## SECTION 2: APPLICANT INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="text"/>	<input type="checkbox"/> Male
<b>1. Last Name</b>	<input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<b>First Name</b>	<input type="checkbox"/> Female
<input type="text"/>	<input type="checkbox"/> Other _____	<b>M.I.</b>	<b>2. Gender</b>
<input type="text"/>		<input type="text"/>	
<b>[3. Social Security Number]</b>		<b>[4.] Street Address</b>	

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

{GLTC-ABCCCompany-App-mm/yy}



[(If Upgrade – ongoing)

**8. Please check one:**

- Option 1:**  I choose to **replace** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} with this coverage.  
**Option 2:**  I choose to **keep** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} **and apply** for this coverage.]

**9. Please choose your desired coverage type:**  Facilities Only Coverage **OR**  Comprehensive Long-Term Care Coverage ]

**10. Please choose your desired benefit.** **OR** **10. Please choose your desired Daily Maximum Benefit (DMB).**

- Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)  
Option 1:  {\$100/\$182,500}  
Option 2:  {\$200/\$365,000}  
Option 3:  {\$300/\$547,500 ]

DMB:  {\$100}  {\$200}  {\$300 ]

**11. Please choose your desired Lifetime Maximum Benefit (LMB). (Note: If you are choosing the Shared Care Benefit, you must choose the {5-year} LMB.)**

LMB:  {2-year}  {5-year}  {Unlimited} ]

[(OR if Employer-Paid is offered)

**10a. If you are an Active Employee, please choose your desired benefit from the list below:**

- Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)  
Option 1:  {\$100/\$182,500} {{Core \$100 DMB; 5-year LMB}}  
Option 2:  {\$150/\$273,750} {{Core \$100 DMB + \$50; 5-year LMB}}  
Option 3:  {\$200/\$365,000} {{Core \$100 DMB + \$100; 5-year LMB}}  
Option 4:  {\$300/\$547,500} {{Core \$100 DMB + \$200; 5-year LMB}}

**10b. If you are (a/an) [Member of the Board of Directors,] [Eligible Retiree] [or] [Eligible Family Member], please choose your desired benefit from the list below:**

- Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)  
Option 1:  {\$100/\$182,500}  
Option 2:  {\$150/\$273,750}  
Option 3:  {\$200/\$365,000}  
Option 4:  {\$300/\$547,500} ]

[(11). **Please choose your desired Qualification Period:**  {60-day}  {90-day} ]

[(12). **Do you wish to choose the Return of Premium at Death Benefit?**  Yes  No ]

[(13). **Do you wish to choose the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit)?**

- Yes**, I elect this benefit.  
 **No**, I have reviewed the Outline of Coverage and Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit) as described therein. Specifically, I have reviewed the plan and reject the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit).]

[(14). **Please choose your desired Inflation Provision. (Please check one.)**

- Future Purchase Option (FPO)  Automatic Benefit Increase (ABI)  Automatic Consumer Price Index (ACPI) ]

[(15). **Do you wish to choose the [Accelerated Payment Option OR Ten-Year Payment Option]?**  Yes  No

(Note: You must have chosen [ABI] [or] [ACPI] in order to choose this option.)]

**[Shared Care Benefit]**

**16. Do you wish to choose the Shared Care Benefit?**  Yes  No

**[(Note: You must have chosen the {5-year} LMB in order to choose the Shared Care Benefit.)]**

If you checked "YES," please provide the following information about your spouse[ or domestic partner]. Both you and your spouse[ or domestic partner] must apply for the Shared Care Benefit; choose all of the same benefits options [(e.g.: DMB, LMB, Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit), and Inflation Provision)]; **and submit your applications together.** If your benefit choices are different or your applications are not submitted together, it will cause a delay in processing by John Hancock.

If you checked "NO," please [continue].

Spouse's[ or Domestic Partner's] Last Name

Spouse's[ or Domestic Partner's] First Name

If you are a Spouse [or Domestic Partner] of an {Active Employee}, please complete {16a}. All others, please complete {16b}.

[16a. Employee ID of (Active Employee)           ]

[16b.] Spouse's [ or Domestic Partner's ] Social Security Number:    -   -     ]

### SECTION 4: STATEMENT OF HEALTH

**PLEASE ANSWER ALL QUESTIONS (#1 - #9) – CONTINUED ON THE NEXT PAGE**

**1. What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_**

**2. Have you used tobacco products in the past 12 months? This means: cigarettes; pipe; cigar; or chewing tobacco. ....**  **Yes**  **No**

**3. Have you consulted with your primary care physician or a specialist within the past 24 months? .....**  **Yes**  **No**

Primary Care Physician's or Specialist's Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

**4. Have you been prescribed or have you taken prescription medications at any time over the past 18 months? .....**  **Yes**  **No**

If yes, please list each medication below.

Name of Medication	Dosage	Frequency	Reason Prescribed	Name of Physician

**5. Within the past 7 years, have you received: medical advice; diagnosis; or treatment from, or consulted with a member of the medical profession for any of the following conditions?**

- a. **Circulatory Disorders:**
  - Transient Ischemic Attack ■ Amaurosis Fugax ■ Heart Arrhythmias ■ Valvular Disease ■ Cardiomyopathy
  - Congestive Heart Failure ■ Aneurysm ■ Coronary Artery Disease ■ High Blood Pressure
  - Peripheral Vascular Disease ■ Carotid Artery Disease ■ Embolisms.....  **Yes**  **No**
- b. **Endocrine & Pituitary Disorders:**
  - Diabetes ■ Addison's Disease ■ Pancreatitis ■ Cushing's Disease.....  **Yes**  **No**
- c. **Cancers:**
  - Leukemia ■ Lymphoma ■ Tumors ■ Melanoma ■ Squamous Cell ■ Sarcomas.....  **Yes**  **No**
- d. **Genitourinary Disorders:**
  - Renal Insufficiency ■ Incontinence ■ Prostate Disorders ■ Bladder Disorders.....  **Yes**  **No**
- e. **Gastrointestinal Disorders:**
  - Hepatitis ■ Ulcerative Colitis ■ Crohn's Disease ■ Liver Disorders.....  **Yes**  **No**
- f. **Neurological Disorders:**
  - Mental Illness ■ Depression ■ Seizures ■ Tremors ■ Neuropathy ■ Syncope ■ Anxiety ■ Chronic Fatigue Syndrome.....  **Yes**  **No**
- g. **Blood Disorders:**
  - Anemia ■ Polycythemia Vera ■ Thrombocytopenia ■ Hemachromatosis ■ Leukopenia .....  **Yes**  **No**
- h. **Musculoskeletal Disorders:**
  - Osteoporosis ■ Arthritis ■ Rheumatoid Arthritis ■ Osteoarthritis ■ Fractures ■ Fibromyalgia ■ Degenerative Joint Disease
  - Scoliosis ■ Spinal Stenosis ■ Lupus ■ Polymyalgia Rheumatica ■ Osteopenia ■ Paralysis .....  **Yes**  **No**
- i. **Respiratory Disorders:**
  - Emphysema ■ Bronchitis ■ Asthma ■ Bronchiectasis ■ Asbestosis ■ Sarcoidosis
  - Chronic Obstructive Pulmonary Disease ■ Pulmonary Fibrosis.....  **Yes**  **No**
- j. **Eye & Ear Disorders:**
  - Macular Degeneration ■ Glaucoma ■ Retinitis Pigmentosa ■ Labrynthitis ■ Meniere's/Vertigo.....  **Yes**  **No**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

k. **Substance Abuse:**  
 ■ Alcoholism ■ Drug dependency ■ Illicit drug use .....

6. **Within the past 7 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?** .....

7. **Within the past 7 years has any surgery or medical test(s) been recommended that have not been performed?**.....

8. **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, please list medical reason: \_\_\_\_\_

9. **Have any of your family members (mother, father, siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions:**

■ Alzheimer’s Disease ■ Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) ■ Dementia ■ Diabetes ■ Heart Disease **Yes** **No**  
 ■ Huntington’s Disease ■ Parkinson’s Disease ■ Stroke? .....

Diagnosis	Relationship (eg. Mother)	Age of Onset

**If you answered “YES” to any of the questions 4 – 8 above regarding your health history, provide full details below.  
 If additional space is needed, please attach a separate sheet.**

Questions (#4 - #8)	Diagnosis, Disorder and/or Reason	Diagnosis Date	Treatment Date	Include Name, Address, Telephone Number of Physician, Provider and/or Insurer (if applicable) and Explanation or Comments

**Summary Notice of Information Practices**  
 In connection with your application for coverage, we may collect personal information from other sources in an effort to confirm, clarify, or supplement the personal information you have supplied on your application. The personal information that we collect may, in certain circumstances, be disclosed to third parties without authorization as permissible by law. You have right of access and correction with respect to all personal information collected. The Notice of Information Practices will be furnished to you upon request.



**Please make sure you answered all questions (#1 - #9) in the Statement of Health Before Proceeding**

## SECTION 5: AGREEMENT & ACKNOWLEDGEMENT

**Agreement** – I hereby apply for the Group Long-Term Care Insurance offered under the group insurance policy issued by John Hancock Life & Health Insurance Company to [ABC Company] (policyholder), and hereby represent and agree that the foregoing statements, together with any explanations contained in this application, are to the best of my knowledge and belief, true and complete; are statements of fact and not opinion; and shall be the basis for issuance of insurance for which I am now applying.

Neither [ABC Company], nor any agent or representative acting on behalf of John Hancock is authorized to make or discharge contracts; waive, alter, modify, or change any of the conditions or provisions of any application or policy; or to accept risks or pass on insurability.

**Applicable to currently insured applicants who want to change their coverage as described in the “Instructions”** – If approved, I understand that I am relinquishing all rights and benefits of my current coverage and replacing them with the rights and benefits of the new coverage.

**[(If Upgrade/Transfer – initial) Applicable to applicants who apply to replace their current coverage]** – If coverage under the new plan is issued to me, I understand that I am relinquishing all rights and benefits of my current coverage under the existing [former carrier] Group Long-Term Care Insurance Plan for [ABC Company] and replacing them with the rights and benefits in the new {ABC Company} Group Long-Term Care Insurance Plan insured through John Hancock.]

**Acknowledgement** – I have received and reviewed: the Outline of Coverage; Shopper’s Guide to Long-Term Care Insurance; Notice of Protected Health Information Privacy Practices; Suitability Form (or Personal Worksheet); and Potential Rate Increase Disclosure Form before completing my application.

**Caution** – If your answers on this application are incorrect or untrue, John Hancock may have the right to deny benefits or rescind your coverage. Please refer to the last page of this application for important notices.



Applicant’s Signature

Date

**Notice: You are required to notify John Hancock of any change in your health that occurs while your application is being reviewed.**

## SECTION 6: AUTHORIZATION

**This Authorization is intended to comply with HIPAA.** “HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all the following information:
  - my medical records and medical history; and
  - other information that relates to:
    - the diagnosis of any physical or mental condition; or
    - the treatment or prognosis of any physical or mental condition,whether such information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life & Health Insurance Company (John Hancock)); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.
3. Health information about me may be disclosed to John Hancock and its affiliates; service providers; reinsurers; agents and representatives; and to any consumer reporting agency such as the MIB.
4. Health information about me may be used or disclosed: in connection with my application; to service my long-term care insurance coverage; and to evaluate any claim for long-term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.

5. I understand that:

- If I do not sign this Authorization, John Hancock may:
  - decline to issue long-term care insurance coverage to me; and
  - decline to pay any claim for such benefits.
- This Authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I understand that I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.



Applicant's Signature \_\_\_\_\_

Applicant's Name (Please Print) \_\_\_\_\_

\_\_\_\_\_  
Date

If this Authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included: \_\_\_\_\_

### SECTION 7: INSURANCE HISTORY – PLEASE ANSWER ALL QUESTIONS (#1 - #4)

**STATE LAW REQUIRES THAT WE ASK YOU THE FOLLOWING QUESTIONS. ALL APPLICANTS MUST COMPLETE THIS SECTION IN ORDER TO APPLY FOR COVERAGE. IF YOU DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

1. Do you have another long-term care policy or certificate in force (including health care service contract, health maintenance organization contract)?.....  Yes  No
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?.....  Yes  No  
 If so, with which company? \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 If that coverage lapsed, when did it lapse? \_\_\_\_\_
3. Are you currently covered by Medicaid? .....  Yes  No
4. Do you intend to replace any of your medical or health insurance coverage with this certificate? .....  Yes  No

## SECTION 8: BILLING & PAYMENT

**{[ACTIVE EMPLOYEES']/[ELIGIBLE RETIREES'] AND THEIR SPOUSES' [OR DOMESTIC PARTNERS'] premiums will be deducted from the paycheck[/pension] of the eligible, actively-at-work (employee)[ or the eligible retiree]. The {Active Employee} [or the Eligible Retiree] must sign the following Payroll[/Pension] Deduction Authorization (even if the [employee][or retiree] does not apply with his/her spouse[ or domestic partner]):**

I hereby authorize my employer[/former employer], [ABC Company], [or a participating subsidiary or affiliate,] to deduct from my salary[/pension] the amount(s) necessary to make the premium contribution for the Group Long-Term Care Insurance coverage under a policy issued by John Hancock Life & Health Insurance Company to [ABC Company], in my name and/or in the name of my spouse[ or domestic partner], if applicable. This authorization may be cancelled only upon written notification to John Hancock from me or the insured.



\_\_\_\_\_ ]  
**{Active Employee's}[/Retiree's] Signature**

\_\_\_\_\_ ]  
**Date**

**ALL [OTHER] APPLICANTS must choose to pay premiums through [monthly automatic bank withdrawal, direct billing, or credit/debit card]. Please choose only one billing option and complete the "Protection Against Unintended Lapse" section located [on the bottom of this page]:**

**Monthly Automatic Bank Withdrawal (ABW).** Please complete the authorization below, AND select the day of the month on which you would like your checking account withdrawn:  5<sup>th</sup> day,  15<sup>th</sup> day, **or**  25<sup>th</sup> day;

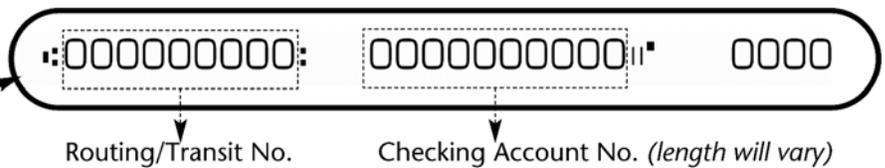
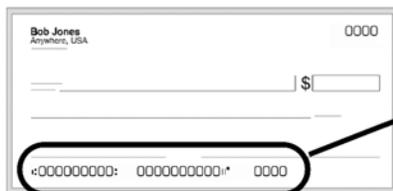
**Direct Billing.**

**Please note:** If you would like your bill sent to an address other than your home address, please contact John Hancock at [1-800-XXX-XXXX]; **OR**

**Credit/Debit Card.** Please provide the following information and sign the authorization below:

[Payment Frequency:	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly]
[Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa]
Card Number: _____	Expiration Date (mm/yy): _____	
Cardholder's Name: _____		
Cardholder's Signature: _____ (if different from the applicant)		

### [Authorization to Honor Payment through ABW or Credit/Debit Card



\_\_\_\_\_ ]  
**Name of bank (and branch, if applicable)**

\_\_\_\_\_ ]  
**Routing/Transit and Checking Account No.**

I authorize John Hancock Life & Health Insurance Company to initiate automatic bank withdrawals from my checking account [or charge my credit/debit card] shown above in order to effect payment of my premium. Also, I authorize my bank [or credit/debit card company] to charge such account [or card] for such withdrawals [or transactions]. I understand that I will not receive any bills or notices of withdrawal [or transaction] from John Hancock. I also understand that if any withdrawal [or transaction] is not honored by my bank [or credit/debit card company] for any reason, I am responsible to pay my premium or my insurance coverage will be terminated. This authorization will remain in effect until I, my bank [or credit/debit card company], or John Hancock terminates it by giving a thirty (30) day written termination notice to the others.



\_\_\_\_\_ ]  
**Applicant's Signature**

\_\_\_\_\_ ]  
**Date**

**If you have a joint checking account, please have the other depositor sign below.**



\_\_\_\_\_ ]  
**Depositor's Signature**

\_\_\_\_\_ ]  
**Date**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

[GLTC-ABCCCompany-App-mm/yy]

## PROTECTION AGAINST UNINTENDED LAPSE

**IF YOU [CHOSE AUTOMATIC BANK WITHDRAWAL, DIRECT BILLING OR CREDIT/DEBIT CARD AND] DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

I choose NOT to name a person to receive this notice.  \_\_\_\_\_  
**Applicant's Signature** **Date**

If you choose to name another person to receive notice of termination, please provide name and address below. (Please print legibly.)

Yes, I am interested in naming the following person to receive this notice.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

## CHECKLIST

**Please make sure you remember to:**

- Answer all questions within each section**
- Sign and date wherever you see a  (where applicable)**
- Tear off and return each page to John Hancock**

**An application that is not completed properly will cause a delay in processing by John Hancock.**

## IMPORTANT NOTICES

**[ARKANSAS, LOUISIANA, and NEW MEXICO RESIDENTS – 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.]

**[CALIFORNIA RESIDENTS –** The certificate is an approved long-term care insurance certificate under California law and regulations. However, the benefits payable by the certificate will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care. For information about policies qualifying under the California Partnership for Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number of 1-800-434-0222.]

**[COLORADO RESIDENTS – Fraud Notice:** 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 for the purpose of defrauding or attempting to defraud the 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 RESIDENTS – 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.]

**[FLORIDA RESIDENTS –** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[HAWAII RESIDENTS –** THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.]

**[ILLINOIS RESIDENTS –** THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED TRADITIONAL LONG-TERM CARE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.]

**[INDIANA RESIDENTS – This certificate does not qualify for Medicaid asset protection under the Indiana Long-Term Care Program. However, this certificate is an approved long-term care insurance certificate under state insurance regulations. For information about policies qualifying under the Indiana Long-Term Care Program, call the Senior Health Insurance Information Program of the Department of Insurance at 1-800-452-4800.]**

**[IOWA RESIDENTS –** THIS CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG-TERM CARE INSURANCE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.]

**[KENTUCKY RESIDENTS –** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[LOUISIANA RESIDENTS – 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.]

**[MAINE, TENNESSEE, VIRGINIA and WASHINGTON RESIDENTS –** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]

**[MICHIGAN RESIDENTS –** For additional information about long-term care coverage, write to the Michigan Insurance Bureau, P.O. Box 30220, Lansing, MI 48909, or call the Area Agency on Aging in your community. ]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

**[NEW JERSEY RESIDENTS** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[NEW YORK RESIDENTS** – 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[OHIO RESIDENTS – Fraud Notice:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**[OKLAHOMA RESIDENTS – 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.]

**[OREGON RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.]

**[PENNSYLVANIA RESIDENTS – Fraud Notice:** 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

**[VERMONT RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

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

***STATEMENT OF VARIABILITY – This page will be revised as additional state notices are added or existing state notices are revised.***

# STREAMLINED APPLICATION FOR INSURANCE UNDER [THE ABC COMPANY] GROUP LONG-TERM CARE INSURANCE PLAN

Underwritten by John Hancock Life & Health Insurance Company (John Hancock), Boston, MA 02117

Group Number: {XXX}  
Form B

## Instructions for first-time applicants

- { [1. If you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit [or are issue age [70] or older]], please complete and submit the enclosed **Application**.]
- [2] [If you are:
- An eligible, actively-at-work {employee} [enrolling/applying] during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - A newly hired eligible or newly eligible, actively-at-work {employee} [enrolling/applying] within {XX} days of first becoming eligible; or ]
  - An {employee} who was on a leave of absence or disability during the designated {XXXX} enrollment period [enrolling/applying] within {XX} days of returning to work on a regular basis;
- please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance** [unless you are [issue age 70 or older] [or] [you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].]
- [3]. [If you are:
- [A spouse[ or domestic partner] or other family member of] **OR** [a/An eligible, actively-at-work {employee}] [or his/her spouse[ or domestic partner] or other family member] applying during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - [A spouse[ or domestic partner] or other family member of] **OR** [a/An eligible, actively-at-work {employee}] [or his/her spouse[ or domestic partner] or other family member] applying within {XX} days of first becoming eligible; or
  - [A spouse[ or domestic partner] or other family member of] **OR** [a/An {employee}] who was on a leave of absence or disability during the designated {XXXX} enrollment period [or his/her spouse[ or domestic partner] or other family member] applying within {XX} days of [the employee's] [returning/return] to work on a regular basis.];
- [Please complete and submit this **Streamlined Application** [unless you are [issue age 70 or older] [or] [you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].]
- [4]. All other applicants {including actively-at-work employees issue age [70] or older} , please complete and submit the enclosed **Application**. An application that is not completed properly will cause a delay in processing by John Hancock.

## Instructions for currently insured applicants who want to change coverage[\*]

### [(If 1 plan design)

1. If you would like to **increase** your coverage, please {complete and submit the enclosed **Application**.} An increase in coverage can be the purchase of a higher Daily Maximum Benefit (DMB)[, higher Lifetime Maximum Benefit (LMB) or adding an optional benefit].
2. If you would like to **decrease** your coverage, please fill in Sections 2, 3 and 4 (Agreement & Acknowledgement) only. A decrease in coverage can be choosing a lower DMB [or LMB or removing an optional benefit from your coverage].
3. If you would like to do both (increase a portion of your coverage and decrease another), please {complete and submit the enclosed **Application A** or fill in all sections.}

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]

### [(OR if 2+ plan designs – ongoing upgrades)

1. If you have coverage under the group long-term care insurance plan originally offered by {ABC Company} insured through John Hancock and would like to:
  - replace that coverage with this newly offered coverage, please {complete and submit the enclosed **Application** }.
  - make changes to your current coverage (and not apply for this newly offered coverage), please call John Hancock at {1-800-xxx-xxxx} for your application.
2. If you already have coverage under this newly offered group long-term care insurance plan insured through John Hancock and would like to:
  - increase your coverage (e.g., purchase a higher Daily Maximum Benefit (DMB) [or add an optional benefit]), please {complete and submit the enclosed **Application A**.}
  - decrease your coverage (e.g., choosing a lower DMB), please fill in Sections 2, 3 and 4 (Agreement & Acknowledgement) only.
  - do both (increase a portion of your coverage and decrease another), please {complete and submit the enclosed **Application A**.}

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[\*Please note: If you want to **keep** your current coverage under the plan originally offered by {ABC Company} insured through John Hancock **and** **apply** for this newly offered coverage, please {complete and submit the enclosed **Application**.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]

IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}

**Please sign and date the application where indicated. Return in the enclosed postage-paid envelope to John Hancock Service Office:**

**John Hancock Life & Health Insurance Company, {Group Long-Term Care Department, B-6, John Hancock Place, P.O. Box 111, Boston, Massachusetts 02117-9939}**

*[If you are a resident of {XX}, please call 1-800-XXX-XXXX for your application.]*

{If you have any questions or would like more applications, please call the John Hancock Long-Term Care Customer Service Center toll-free at **1-800-XXX-XXXX**. Outside the United States, the number is {(617) 572-0048}. The TTY number for the hearing impaired is 1-800-255-1808. You can also visit our Long-Term Care Web site at [www.jhancock.com/gltc](http://www.jhancock.com/gltc), or email us at [gltc@jhancock.com](mailto:gltc@jhancock.com).}

**Please note:** You must meet all eligibility requirements (as described in the Plan Summary) in order for this coverage to go into effect.

## SECTION 1: ANSWER THESE QUESTIONS FIRST

**Please check "YES" or "NO" beside each question:**

1. **Within the past 7 years, have you received: medical advice; diagnosis; or treatment from a member of the medical profession for:**
  - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or Human Immunodeficiency Virus (HIV)
  - Alzheimer's Disease, Cognitive Impairment, Dementia, or Memory Loss ■ Amyotrophic Lateral Sclerosis ■ Cerebral Atrophy
  - Cirrhosis ■ Crest ■ Cystic Fibrosis ■ Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney
  - Huntington's Chorea ■ Kidney Disease ■ Mental Retardation ■ Metastatic Cancer ■ Mixed Connective Tissue Disease
  - Multiple Myeloma ■ Multiple Sclerosis ■ Possible Multiple Sclerosis ■ Muscular Dystrophy ■ Myasthenia Gravis
  - Neurological conditions affecting the brain or spinal cord ■ Parkinson's Disease ■ Polyneuropathy ■ Post-Polio Paralytic Syndrome
  - Schizophrenia ■ Scleroderma ■ Spinal Cord Injury ■ Stroke/CVA ■ Systemic Lupus Erythematosus
  - Transient Ischemic Attacks (2 or more)?..... Yes No
2. **Do you require human assistance or supervision in any of the following activities:**
  - eating ■ dressing ■ toileting ■ transferring from bed to chair ■ walking ■ maintaining continence ■ bathing?..... □ □
3. **Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home; assisted care living facility or other custodial facility; or are you currently receiving home health care services or attending adult day care? .....** □ □
4. **Do you currently use any of the following medical devices:**
  - wheelchair ■ walker ■ hospital bed ■ quad cane ■ oxygen ■ stairlift ■ dialysis?..... □ □
5. **Are you currently receiving Social Security Disability; Worker's Compensation; or Long-Term Disability Benefits? .....** □ □



**If you answered "YES" to any of questions 1 – 5 above, we suggest that you do not submit an application; we will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue.**

[ABC Company] – Group Number {XXX}

## SECTION 2: APPLICANT INFORMATION (PLEASE PRINT)

<p>1. Last Name</p> <p>[3.] Social Security Number</p> <p>City/Town</p> <p>[5.] Home Phone</p> <p>[8.] Email Address (optional)</p>	<p>[4.] Street Address</p> <p>State[/Territory]</p> <p>Month Day</p> <p>7. Date of Birth</p>	<p>2. Gender</p> <p>[6.] Work Phone</p> <p>Year</p>	<p>□ Mr. □ Mrs.</p> <p>□ Ms. □ Miss</p> <p>□ Other _____</p> <p>□ Male</p> <p>□ Female</p> <p>M.I.</p>
---	--	---	--

This box is used only when enrolling with Employee ID.

**THIS BOX FOR INTERNAL USE ONLY**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}**

## SECTION 3: GENERAL INFORMATION

### 1. Which term applies to you? (Please check one.)

- |   |  |
|---|--|
| <input type="checkbox"/> Active Employee*   | <input type="checkbox"/> Member of the Board of Directors]   |
| <input type="checkbox"/> Spouse of {Active Employee*}]  | <input type="checkbox"/> Spouse of Member of the Board of Directors]   |
| <input type="checkbox"/> Domestic Partner of {Active Employee*}]  | <input type="checkbox"/> Domestic Partner of Member of the Board of Directors]   |
| <input type="checkbox"/> Surviving Spouse of {Employee}]  | <input type="checkbox"/> Eligible Retiree]   |
| <input type="checkbox"/> Parent or Parent-in-Law of {Active Employee*}]   | <input type="checkbox"/> Spouse of Eligible Retiree]   |
| <input type="checkbox"/> Sibling/Spouse of Sibling of {Active Employee*} or of<br>{Active Employee's} Spouse[ or Domestic Partner]]         | <input type="checkbox"/> Domestic Partner of Eligible Retiree]   |
| <input type="checkbox"/> Adult Child/Spouse of Adult Child of {Active Employee*} or of<br>{Active Employee's} Spouse[ or Domestic Partner]] | <input type="checkbox"/> Surviving Spouse of Retiree]  |
| <input type="checkbox"/> Grandparent or Grandparent-in-Law of {Active Employee*}]   | <input type="checkbox"/> Parent or Parent-in-Law of Eligible Retiree]  |
|   | <input type="checkbox"/> Sibling/Spouse of Sibling of Eligible Retiree or of<br>Eligible Retiree's Spouse[ or Domestic Partner]]         |
|   | <input type="checkbox"/> Adult Child/Spouse of Adult Child of Eligible Retiree or of<br>Eligible Retiree's Spouse[ or Domestic Partner]] |
|   | <input type="checkbox"/> Grandparent or Grandparent-in-Law of Eligible Retiree]  |

{\*Active Employee means an eligible employee who is actively at work. An employee on a leave of absence or disability is not considered an Active Employee for purposes of this enrollment.}

### 2. Are you married[ or in a committed relationship with a domestic partner]? Yes No

**Note: If you checked {Active Employee}, please skip to question {4 or 5}. If you checked [Member of the Board of Directors, Eligible Retiree or Surviving Spouse], please skip to question {8}. All others go to question {3}.**

### 3. Name of {Active Employee or Eligible Retiree or Member of the Board of Directors} through whom you are applying for coverage:

Last Name       First Name       M.I.      ]
 Employee ID field & corresponding box.

### 4. [Social Security Number/Employee ID] of {Active Employee or

**Eligible Retiree or Member of the Board of Directors}**       -  -  **OR**  ]  
 [(leading zeroes NOT required)]:  
THIS BOX FOR INTERNAL USE ONLY

### 5. If the {Active Employee} was on a leave of absence or disability during the designated {XXXX} enrollment period

(mm/dd/yy – mm/dd/yy), when did the leave/disability begin?  
 and end?                        
Month      Day      Year      Month      Day      Year

### 6. {Active Employee's} hire/eligibility date:

Month      Day      Year

### 7. Print name of {Active Employee's} [ABC Company] below. If you are not sure of the company name, please review the enclosed company list (Example: [ABC Company]): \_\_\_\_\_

## BENEFIT OPTIONS (explanations of these provisions are in the enclosed enrollment materials)

[(If Upgrade/Transfer - initial)

### 8. Please check one:

- Option 1:**  I choose to **replace** my current coverage under the existing [{{former carrier}}] Group Long-Term Care Insurance Plan for {ABC Company} with this coverage.
- Option 2:**  I choose to **keep** my current coverage under the existing [{{former carrier}}] Group Long-Term Care Insurance Plan for {ABC Company} **and apply** for this coverage.]

[(If Upgrade – ongoing)

### 8. Please check one:

- Option 1:**  I choose to **replace** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} with this coverage.
- Option 2:**  I choose to **keep** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} **and apply** for this coverage.]

### 9. Please choose your desired coverage type: Facilities Only Coverage **OR** Comprehensive Long-Term Care Coverage ]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}**

**[10. Please choose your desired benefit.**

Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)

- Option 1:  {\$100/\$182,500}
- Option 2:  {\$200/\$365,000}
- Option 3:  {\$300/\$547,500}

**OR [10. Please choose your desired Daily Maximum Benefit (DMB).**

DMB:  [\$100]  [\$200]  [\$300]

**[11. Please choose your desired Lifetime Maximum Benefit (LMB).**

LMB:  [2-year]  [5-year]

**[[11]. Please choose your desired Qualification Period:  {60-day}  {90-day} ]**

**[[12]. Do you wish to choose the Return of Premium at Death Benefit?  Yes  No]**

**[[13]. Do you wish to choose the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit)?**

- Yes**, I elect this benefit.
- No**, I have reviewed the Outline of Coverage and Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit) as described therein. Specifically, I have reviewed the plan and reject the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit).]

**[[14]. Please choose your desired Inflation Provision. (Please check one.)**

- Future Purchase Option (FPO)  Automatic Benefit Increase (ABI)  Automatic Consumer Price Index (ACPI)

**[[15]. Do you wish to choose the [Accelerated Payment Option OR Ten-Year Payment Option]?  Yes  No**

**(Note: You must have chosen [ABI] [or] [ACPI] in order to choose this option.)]**

## **SECTION 4: AGREEMENT & ACKNOWLEDGEMENT – PLEASE SIGN AND DATE BELOW**

**Agreement** – I hereby apply for the Group Long-Term Care Insurance offered under the group insurance policy issued by John Hancock Life & Health Insurance Company to [ABC Company] (policyholder), and hereby represent and agree that the foregoing statements, together with any explanations contained in this application, are to the best of my knowledge and belief, true and complete; are statements of fact and not opinion; and shall be the basis for issuance of insurance for which I am now applying.

Neither [ABC Company], nor any agent or representative acting on behalf of John Hancock is authorized to make or discharge contracts; waive, alter, modify, or change any of the conditions or provisions of any application or policy; or to accept risks or pass on insurability.

**Applicable to currently insured applicants who want to change their coverage as described in the “Instructions”** – If approved, I understand that I am relinquishing all rights and benefits of my current coverage and replacing them with the rights and benefits of the new coverage.]

**[(If Upgrade/Transfer – initial) Applicable to applicants who apply to replace their current coverage** – If coverage under the new plan is issued to me, I understand that I am relinquishing all rights and benefits of my current coverage under the existing [former carrier] Group Long-Term Care Insurance Plan for [ABC Company] and replacing them with the rights and benefits in the new [ABC Company] Group Long-Term Care Insurance Plan insured through John Hancock.]

**Acknowledgement** – I have received and reviewed: the Outline of Coverage; Shopper’s Guide to Long-Term Care Insurance; Notice of Protected Health Information Privacy Practices; Suitability Form (or Personal Worksheet); and Potential Rate Increase Disclosure Form before completing my application.

**Caution – If your answers on this application are incorrect or untrue, John Hancock may have the right to deny benefits or rescind your coverage.**

**Please refer to the last page of this application for important notices.**



\_\_\_\_\_  
**Applicant’s Signature**

\_\_\_\_\_  
**Date**

**Notice: You are required to notify John Hancock of any change in your health that occurs while your application is being reviewed.**

## SECTION 5: INSURANCE HISTORY – PLEASE ANSWER ALL QUESTIONS (#1 - #4)

**STATE LAW REQUIRES THAT WE ASK YOU THE FOLLOWING QUESTIONS. ALL APPLICANTS MUST COMPLETE THIS SECTION IN ORDER TO APPLY FOR COVERAGE. IF YOU DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

1. Do you have another long-term care policy or certificate in force (including health care service contract, health maintenance organization contract)?.....  Yes  No
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?.....  Yes  No  
 If so, with which company? \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 If that coverage lapsed, when did it lapse? \_\_\_\_\_
3. Are you currently covered by Medicaid? .....  Yes  No
4. Do you intend to replace any of your medical or health insurance coverage with this certificate? .....  Yes  No

## SECTION 6: BILLING & PAYMENT

**[{ACTIVE EMPLOYEES'}[ AND THEIR SPOUSES'[ OR DOMESTIC PARTNERS'] premiums will be deducted from the paycheck of the eligible, actively-at-work {employee}. The {Active Employee} must sign the following Payroll Deduction Authorization (even if the [employee] does not apply with his/her spouse[ or domestic partner]):**

I hereby authorize my employer, [ABC Company], [or a participating subsidiary or affiliate,] to deduct from my salary the amount(s) necessary to make the premium contribution for the Group Long-Term Care Insurance coverage under a policy issued by John Hancock Life & Health Insurance Company to [ABC Company], in my name and/or in the name of my spouse[ or domestic partner], if applicable. This authorization may be cancelled only upon written notification to John Hancock from me or the insured.



\_\_\_\_\_ ]  
**{Active Employee's} Signature**

\_\_\_\_\_ ]  
**Date**

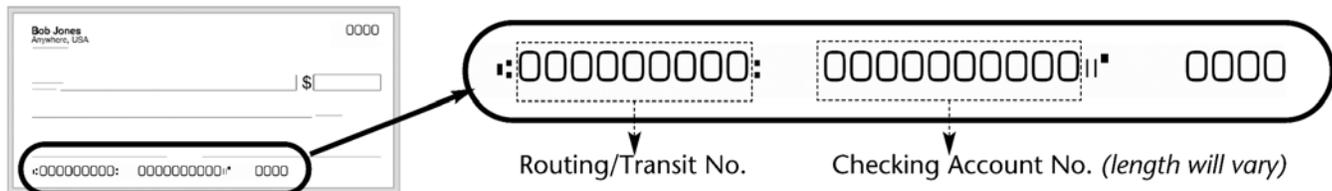
**ALL [OTHER] APPLICANTS must choose to pay premiums through [monthly automatic bank withdrawal, direct billing, or credit/debit card]. Please choose only one billing option and complete the "Protection Against Unintended Lapse" section located [on the bottom of this page]:**

- Monthly Automatic Bank Withdrawal (ABW).** Please **attach a voided check**, sign the authorization below, AND select the day of the month on which you would like your checking account withdrawn:  5<sup>th</sup> day,  15<sup>th</sup> day, **or**  25<sup>th</sup> day;
- Direct Billing.**  
**Please note:** If you would like your bill sent to an address other than your home address, please contact John Hancock at [1-800-XXX-XXXX]; **OR**
- Credit/Debit Card.** Please provide the following information and sign the authorization below:

[Payment Frequency:	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly]	
[Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa]	
Card Number: _____	Expiration Date (mm/yy): _____		
Cardholder's Name: _____			
Cardholder's Signature: _____ (if different from the applicant)			

]

**[Authorization to Honor Payment through ABW or Credit/Debit Card**



**Name of bank (and branch, if applicable)**

**Routing/Transit and Checking Account No.**

---

I authorize John Hancock Life & Health Insurance Company to initiate automatic bank withdrawals from my checking account [or charge my credit/debit card] shown above in order to effect payment of my premium. Also, I authorize my bank [or credit/debit card company] to charge such account [or card] for such withdrawals [or transactions]. I understand that I will not receive any bills or notices of withdrawal [or transaction] from John Hancock. I also understand that if any withdrawal [or transaction] is not honored by my bank [or credit/debit card company] for any reason, I am responsible to pay my premium or my insurance coverage will be terminated. This authorization will remain in effect until I, my bank [or credit/debit card company], or John Hancock terminates it by giving a thirty (30) day written termination notice to the others.



\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

**If you have a joint checking account, please have the other depositor sign below.**



\_\_\_\_\_  
**Depositor's Signature**

\_\_\_\_\_  
**Date** ]

**PROTECTION AGAINST UNINTENDED LAPSE**

**IF YOU [CHOSE AUTOMATIC BANK WITHDRAWAL, DIRECT BILLING OR CREDIT/DEBIT CARD AND] DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

I choose NOT to name a person to receive this notice. \_\_\_\_\_  
**Applicant's Signature** **Date**

If you choose to name another person to receive notice of termination, please provide name and address below. **(Please print legibly.)**

Yes, I am interested in naming the following person to receive this notice.

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip

## CHECKLIST

**Please make sure you remember to:**

- Answer all questions within each section**
- Sign and date wherever you see a  (where applicable)**
- Tear off and return each page to John Hancock**

**An application that is not completed properly will cause a delay in processing by John Hancock.**

## IMPORTANT NOTICES

**[ARKANSAS, LOUISIANA, and NEW MEXICO RESIDENTS – 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.]

**[CALIFORNIA RESIDENTS –** The certificate is an approved long-term care insurance certificate under California law and regulations. However, the benefits payable by the certificate will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care. For information about policies qualifying under the California Partnership for Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number of 1-800-434-0222.]

**[COLORADO RESIDENTS – Fraud Notice:** 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 for the purpose of defrauding or attempting to defraud the 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 RESIDENTS – 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.]

**[FLORIDA RESIDENTS –** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[HAWAII RESIDENTS –** THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.]

**[ILLINOIS RESIDENTS –** THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED TRADITIONAL LONG-TERM CARE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.]

**[INDIANA RESIDENTS – This certificate does not qualify for Medicaid asset protection under the Indiana Long-Term Care Program. However, this certificate is an approved long-term care insurance certificate under state insurance regulations. For information about policies qualifying under the Indiana Long-Term Care Program, call the Senior Health Insurance Information Program of the Department of Insurance at 1-800-452-4800.]**

**[IOWA RESIDENTS –** THIS CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG-TERM CARE INSURANCE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.]

**[KENTUCKY RESIDENTS –** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[LOUISIANA RESIDENTS – 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.]

**[MAINE, TENNESSEE and VIRGINIA and WASHINGTON RESIDENTS –** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

**[MICHIGAN RESIDENTS –** For additional information about long-term care coverage, write to the Michigan Insurance Bureau, P.O. Box 30220, Lansing, MI 48909, or call the Area Agency on Aging in your community.]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}**

**[NEW JERSEY RESIDENTS** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[NEW YORK RESIDENTS** – 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[OHIO RESIDENTS – Fraud Notice:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**[OKLAHOMA RESIDENTS – 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.]

**[OREGON RESIDENTS – WARNING:** Any person who knowingly, and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.]

**[PENNSYLVANIA RESIDENTS – Fraud Notice:** 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

**[VERMONT RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

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

***STATEMENT OF VARIABILITY – This page will be revised as additional state notices are added or existing state notices are revised.***

SERFF Tracking Number: MULF-128177503 State: Arkansas  
 Filing Company: John Hancock Life & Health Insurance Company State Tracking Number:  
 Company Tracking Number:  
 TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified  
 Product Name: GLTC, new business rates, 2012  
 Project Name/Number: GLTC, new business rates, 2012/GLTC, new business rates, 2012

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:** Neutral

**Overall Percentage of Last Rate Revision:** 0.000%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
John Hancock Life & Health Insurance Company	%	%				%	%

SERFF Tracking Number: MULF-128177503 State: Arkansas  
 Filing Company: John Hancock Life & Health Insurance Company State Tracking Number:  
 Company Tracking Number:  
 TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified  
 Product Name: GLTC, new business rates, 2012  
 Project Name/Number: GLTC, new business rates, 2012/GLTC, new business rates, 2012

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 07/06/2012	rates from actuarial memorandum	P-FACE(2009-12), et al.	New		Rate tables.pdf

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Monthly Rates and Premium adjustment factors for all Premium classes:**

**Monthly Base rates by Issue Age**

Issue Age	Monthly Base Rates per \$5 of NH DMB		
	FPO	ABI	ACPI
30	1.0462	9.3100	2.1868
40	1.3504	9.4312	2.4581
45	1.6504	9.5540	2.8557
50	2.1296	10.1659	3.4336
55	2.7582	10.8870	4.1257
60	3.9546	12.8020	6.5711
65	5.3114	13.9367	7.8979
70	7.7303	16.7855	9.9054
80	20.9803	28.8087	24.4875

**Alternate Care Facility (ACF)**

Issue Age	50% ACF			60% ACF		
	FPO	ABI	ACPI	FPO	ABI	ACPI
30	0.9220	0.9420	0.9350	0.9420	0.9660	0.9590
40	0.9080	0.9410	0.9320	0.9320	0.9650	0.9570
45	0.9000	0.9390	0.9280	0.9260	0.9640	0.9550
50	0.8930	0.9300	0.9190	0.9210	0.9570	0.9470
55	0.8850	0.9210	0.9090	0.9150	0.9490	0.9390
60	0.8820	0.9170	0.9050	0.9130	0.9460	0.9360
65	0.8800	0.9120	0.8990	0.9120	0.9420	0.9310
70	0.8760	0.9010	0.8900	0.9100	0.9330	0.9230
80	0.8660	0.8820	0.8730	0.9040	0.9180	0.9100

Issue Age	75% ACF			100% ACF
	FPO	ABI	ACPI	All Inflation Opts
30	0.9670	0.9870	0.9830	1.0000
40	0.9620	0.9870	0.9820	1.0000
45	0.9590	0.9860	0.9810	1.0000
50	0.9560	0.9830	0.9770	1.0000
55	0.9530	0.9780	0.9720	1.0000
60	0.9530	0.9770	0.9700	1.0000
65	0.9530	0.9740	0.9670	1.0000
70	0.9520	0.9690	0.9630	1.0000
80	0.9490	0.9590	0.9540	1.0000

**Benefit period (BP)**

All Ages	<u>2 year</u>	<u>3 year</u>	<u>4 year</u>	<u>5 year</u>	<u>6 year</u>	<u>7 year</u>
		0.7100	0.8600	0.9500	1.0000	1.0500
All Ages	<u>10 year</u>	<u>20 year</u>	<u>Unlimited</u>			
	1.4600	1.5600	1.6200			

**Commissions and Fees**

Premium Rate Adjustment Factor =  $1 / (1 - (1.1 \times \text{Level Amount Payable}))$  rounded to 4 decimal places

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Daily/Monthly Benefit Payment Option for Home and Community Care**

	Daily	Monthly		
	All HC Options	FPO	ABI	ACPI
All ages	1.0000	1.0900	1.0300	1.0400

**Enhanced Home Benefit**

Issue Age	FPO				
	50% HC	60% HC	75% HC	100% HC	None or 0%HC
30	1.1920	1.1400	1.0780	1.0000	1.0000
40	1.1290	1.0950	1.0540	1.0000	1.0000
45	1.0960	1.0710	1.0410	1.0000	1.0000
50	1.0700	1.0510	1.0300	1.0000	1.0000
55	1.0440	1.0330	1.0190	1.0000	1.0000
60	1.0200	1.0150	1.0090	1.0000	1.0000
65	1.0000	1.0000	1.0000	1.0000	1.0000
70	1.0000	1.0000	1.0000	1.0000	1.0000
80	1.0000	1.0000	1.0000	1.0000	1.0000

Issue Age	ABI				
	50% HC	60% HC	75% HC	100% HC	None or 0%HC
30	1.0440	1.0330	1.0190	1.0000	1.0000
40	1.0370	1.0270	1.0160	1.0000	1.0000
45	1.0310	1.0230	1.0140	1.0000	1.0000
50	1.0250	1.0180	1.0110	1.0000	1.0000
55	1.0180	1.0140	1.0080	1.0000	1.0000
60	1.0100	1.0080	1.0040	1.0000	1.0000
65	1.0000	1.0000	1.0000	1.0000	1.0000
70	1.0000	1.0000	1.0000	1.0000	1.0000
80	1.0000	1.0000	1.0000	1.0000	1.0000

Issue Age	ACPI				
	50% HC	60% HC	75% HC	100% HC	None or 0%HC
30	1.0800	1.0590	1.0340	1.0000	1.0000
40	1.0600	1.0440	1.0250	1.0000	1.0000
45	1.0480	1.0360	1.0210	1.0000	1.0000
50	1.0370	1.0270	1.0160	1.0000	1.0000
55	1.0250	1.0190	1.0110	1.0000	1.0000
60	1.0130	1.0100	1.0060	1.0000	1.0000
65	1.0000	1.0000	1.0000	1.0000	1.0000
70	1.0000	1.0000	1.0000	1.0000	1.0000
80	1.0000	1.0000	1.0000	1.0000	1.0000

**Group Specific Factors**

	FPO	ABI	ACPI
All ages	0.85 to 1.35	0.85 to 1.35	0.85 to 1.35

**Home and Community Care**

	Home and Community Based Care	Home and Community Professional Care	None (NH/ ACF only)
All ages	1.1100	1.0000	1.0000

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Home and Community Care %**

Issue Age	0% HC*	50% HC	60% HC	75% HC	100% HC
30	0.8770	0.8934	0.9410	1.0000	1.0962
40	0.8701	0.9018	0.9460	1.0000	1.0876
45	0.8661	0.9080	0.9490	1.0000	1.0826
50	0.8606	0.9142	0.9534	1.0000	1.0758
55	0.8560	0.9200	0.9562	1.0000	1.0700
60	0.8522	0.9242	0.9590	1.0000	1.0652
65	0.8507	0.9286	0.9624	1.0000	1.0634
70	0.8466	0.9338	0.9644	1.0000	1.0582
80	0.8376	0.9414	0.9670	1.0000	1.0470

\*NH / ACF Facility Only plan

**Informal Care**

All ages = (1+ ((duration / 30) x (reimbursement level / 5%) x .006)) / 1.03, rounded to 4 decimals

**Monthly Cash Benefit**

	50% HC	60% HC	75% HC	100% HC
None	1.0000	1.0000	1.0000	1.0000
3 day /10%	1.0750	1.0900	1.1000	1.1350
6day / 20%	1.1500	1.1800	1.2000	1.2700

**Nonforfeiture Benefit**

	None or Contingent Nonforfeiture	RLM Nonforfeiture Benefit
all ages	1.0000	1.0800

**Premium Payment Options**

Issue Age	Lifetime Payment	Ten-Year Payment	Accelerated Payment
30	1.0000	4.0000	1.5500
40	1.0000	3.3200	1.6300
45	1.0000	3.1400	1.8400
50	1.0000	3.0000	2.0400
55	1.0000	2.6800	2.6800
60	1.0000	2.4200	2.4200
65	1.0000	2.0600	2.0600
70	1.0000	1.7000	1.7000
80	1.0000	1.3600	1.3600

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Qualification Period**

Issue Age	30 day	60 day	90 day
30	1.1160	1.0794	1.0000
40	1.1340	1.0894	1.0000
45	1.1440	1.0946	1.0000
50	1.1510	1.0980	1.0000
55	1.1568	1.1012	1.0000
60	1.1632	1.1038	1.0000
65	1.1748	1.1082	1.0000
70	1.1972	1.1136	1.0000
80	1.2810	1.1376	1.0000

**Restoration of Benefits (RoB)**

Benefit Period	all ages			None
	after 6 months	after 12 months	after 24 months	
2	1.1751	1.1022	1.0300	1.0000
3	1.1222	1.0709	1.0200	1.0000
4	1.0960	1.0554	1.0150	1.0000
5	1.0700	1.0400	1.0100	1.0000
6	1.0648	1.0369	1.0090	1.0000
7	1.0597	1.0339	1.0080	1.0000
10	1.0442	1.0247	1.0050	1.0000
20	1.0238	1.0125	1.0010	1.0000
Lifetime	1.0000	1.0000	1.0000	1.0000

**Return of Premium (RoP)**

Issue Age	None	Rop to 70	Rop to 75
30	1.0000	1.0450	1.1476
40	1.0000	1.0526	1.1338
45	1.0000	1.0554	1.1446
50	1.0000	1.0512	1.1448
55	1.0000	1.0436	1.1218
60	1.0000	1.0326	1.0984
65	1.0000	1.0090	1.0500
70	1.0000	1.0000	1.0168
80	1.0000	1.0000	1.0000

**Shared Care**

All ages	<u>4 year</u> 1.0600	<u>5 year</u> 1.0800	<u>6 year</u> 1.0700
All ages	<u>7 year</u> 1.0600	<u>10 year</u> 1.0400	<u>None</u> 1.0000

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Rate calculation**

- 1) Multiply all rate factors for each of the pricing pivot ages listed above.
- 2) Interpolate geometrically to get rates for all ages  
example:      Age 31 rate = (Age 30 rate) \* (Age 40 rate / Age 30 rate)<sup>(1/10)</sup>  
                    Age 32 rate = (Age 31 rate) \* (Age 40 rate / Age 30 rate)<sup>(1/10)</sup>  
                    Age 46 rate = (Age 45 rate) \* (Age 50 rate / Age 45 rate)<sup>(1/5)</sup>  
                    and so on.
- 3) For ages 81 to 85, the following extrapolation formula is applied:

Age 81 rate =	110%	of Age 80 rate
Age 82 rate =	120%	of Age 80 rate
Age 83 rate =	133%	of Age 80 rate
Age 84 rate =	146%	of Age 80 rate
Age 85 rate =	177%	of Age 80 rate
- 4) Round each rate to 2 decimals.  
These are the monthly rates per \$5 of DMB.
- 5) Multiply by the number of \$5 units for the requested DMB.

**Premium Rate calculation example**

Inflation Option	FPO	Informal Care	30 days @ 25%
ACF	100%	Monthly Cash Benefit	none
Benefit period	5 years	Nonforfeiture	RLM
Commissions	none	Premium Payment	Lifetime
Daily/Monthly Benefit	daily	Qualification period	90 days
EHBP	yes	ROB	after 24 mths
Group Specific Factor	1.0000	ROP	none
Home and Community Care	Professional Care	Shared Care	none
Home and Community Care %	75%		

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

**Calculation:**

Issue Age	Monthly Base Rates	ACF	Benefit Period	Commissions	Daily/Monthly Benefit	EHBP
30	1.0462	1.0000	1.0000	1.0000	1.0000	1.0780
40	1.3504	1.0000	1.0000	1.0000	1.0000	1.0540
45	1.6504	1.0000	1.0000	1.0000	1.0000	1.0410
50	2.1296	1.0000	1.0000	1.0000	1.0000	1.0300
55	2.7582	1.0000	1.0000	1.0000	1.0000	1.0190
60	3.9546	1.0000	1.0000	1.0000	1.0000	1.0090
65	5.3114	1.0000	1.0000	1.0000	1.0000	1.0000
70	7.7303	1.0000	1.0000	1.0000	1.0000	1.0000
80	20.9803	1.0000	1.0000	1.0000	1.0000	1.0000

	Group Specific Factor	Home and Community Care	HC%	Informal Care	Monthly Cash Benefit	Nonforfeiture
30	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
40	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
45	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
50	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
55	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
60	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
65	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
70	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800
80	1.0000	1.0000	1.0000	1.0000	1.0000	1.0800

	Premium Payment Option	Qualification Period	RoB	RoP	Shared Care	Product
30	1.0000	1.0000	1.0100	1.0000	1.0000	<b>1.2302</b>
40	1.0000	1.0000	1.0100	1.0000	1.0000	<b>1.5525</b>
45	1.0000	1.0000	1.0100	1.0000	1.0000	<b>1.8741</b>
50	1.0000	1.0000	1.0100	1.0000	1.0000	<b>2.3927</b>
55	1.0000	1.0000	1.0100	1.0000	1.0000	<b>3.0658</b>
60	1.0000	1.0000	1.0100	1.0000	1.0000	<b>4.3525</b>
65	1.0000	1.0000	1.0100	1.0000	1.0000	<b>5.7936</b>
70	1.0000	1.0000	1.0100	1.0000	1.0000	<b>8.4322</b>
80	1.0000	1.0000	1.0100	1.0000	1.0000	<b>22.8853</b>

**John Hancock Life & Health Insurance Company**  
**Group Long-Term Care Insurance Policy and Certificate**  
**Monthly Rates and Premium Adjustment Factors for all Premium Classes**

Monthly premium rates per \$5 of NH DMB for the above case example:

Age	Final rate	Interpolation of above rates	
<b>30 and below</b>	<b>\$1.23</b>	<b>1.2302</b>	
31	\$1.26	1.2592	
32	\$1.29	1.2888	
33	\$1.32	1.3192	
34	\$1.35	1.3502	
35	\$1.38	1.3820	
36	\$1.41	1.4145	
37	\$1.45	1.4478	
38	\$1.48	1.4819	
39	\$1.52	1.5168	
<b>40</b>	<b>\$1.55</b>	<b>1.5525</b>	
41	\$1.61	1.6121	
42	\$1.67	1.6739	
43	\$1.74	1.7382	
44	\$1.80	1.8049	
<b>45</b>	<b>\$1.87</b>	<b>1.8741</b>	
46	\$1.97	1.9679	
47	\$2.07	2.0665	
48	\$2.17	2.1699	
49	\$2.28	2.2786	
<b>50</b>	<b>\$2.39</b>	<b>2.3927</b>	
51	\$2.51	2.5143	
52	\$2.64	2.6421	
53	\$2.78	2.7764	
54	\$2.92	2.9175	
<b>55</b>	<b>\$3.07</b>	<b>3.0658</b>	
56	\$3.29	3.2884	
57	\$3.53	3.5271	
58	\$3.78	3.7832	
59	\$4.06	4.0579	
<b>60</b>	<b>\$4.35</b>	<b>4.3525</b>	
61	\$4.61	4.6087	
62	\$4.88	4.8800	
63	\$5.17	5.1673	
64	\$5.47	5.4715	
<b>65</b>	<b>\$5.79</b>	<b>5.7936</b>	
66	\$6.25	6.2452	
67	\$6.73	6.7320	
68	\$7.26	7.2568	
69	\$7.82	7.8225	
<b>70</b>	<b>\$8.43</b>	<b>8.4322</b>	
71	\$9.32	9.3176	
72	\$10.30	10.2959	
73	\$11.38	11.3770	
74	\$12.57	12.5715	
75	\$13.89	13.8915	
76	\$15.35	15.3501	
77	\$16.96	16.9618	
78	\$18.74	18.7428	
79	\$20.71	20.7107	extrapolation
<b>80</b>	<b>\$22.89</b>	<b>22.8853</b>	factors
81	\$25.17	25.1738	1.1000
82	\$27.46	27.4624	1.2000
83	\$30.44	30.4375	1.3300
84	\$33.41	33.4126	1.4600
<b>85 and above</b>	<b>\$40.51</b>	<b>40.5070</b>	1.7700

SERFF Tracking Number: MULF-128177503 State: Arkansas  
 Filing Company: John Hancock Life & Health Insurance Company State Tracking Number:  
 Company Tracking Number:  
 TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified  
 Product Name: GLTC, new business rates, 2012  
 Project Name/Number: GLTC, new business rates, 2012/GLTC, new business rates, 2012

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved	07/06/2012
<b>Comments:</b>		
<b>Attachment:</b> FLESCH SCORE CERTIFICATION.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved	07/06/2012
<b>Comments:</b> Attached below are our new standard underwriting and streamlined underwriting applications, based on our modified underwriting standards. We will be using all forms contained in this filing with other approved forms under a previously approved group long-term care insurance form/rate filing, state tracking number 38898, approved on 6/2/2008. The previously approved applications with which these forms could be used are GLTC-PHAPP(2009) - group policyholder master application and GLTC ENR(2009) - our guaranteed issue enrollment form.		
<b>Attachments:</b> GLTC_APP_STD(2009-12).pdf GLTC_APP_STREAM(2009-12).pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Health - Actuarial Justification	Approved	07/06/2012
<b>Comments:</b>		
<b>Attachment:</b> P-FACE(2009-12) Actuarial Memo.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved	07/06/2012
<b>Comments:</b> We will be using the forms contained in this filing with form GLTC-DIS(2009). That form is the outline of coverage previously approved under state tracking number 38898 on 6/2/2008.		

SERFF Tracking Number: MULF-128177503 State: Arkansas  
Filing Company: John Hancock Life & Health Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: LTC03G Group Long Term Care Sub-TOI: LTC03G.001 Qualified  
Product Name: GLTC, new business rates, 2012  
Project Name/Number: GLTC, new business rates, 2012/GLTC, new business rates, 2012

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Cover Letter	Approved	<b>Date:</b> 07/06/2012
<b>Comments:</b>		
<b>Attachment:</b>		
Final Cover Letter.pdf		

## FLESCH SCORE CERTIFICATION

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



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

Date: May 30, 2012

# APPLICATION FOR INSURANCE UNDER [THE ABC COMPANY] GROUP LONG-TERM CARE INSURANCE PLAN

Underwritten by John Hancock Life & Health Insurance Company (John Hancock), Boston, MA 02117

Group Number: {XXX}  
Form A

## Instructions for first-time applicants

1. [If you are:
  - An eligible, actively-at-work {employee} [enrolling/applying] during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - A newly hired eligible or newly eligible, actively-at-work {employee} [enrolling/applying] within {XX} days of first becoming eligible; or
  - An {employee} who was on a leave of absence or disability during the designated {XXXX} enrollment period [enrolling/applying] within {XX} days of returning to work on a regular basis;]please complete and submit the enclosed [**Employee Enrollment Form for Automatic Acceptance or Streamlined Application,**] [unless you are issue age 70 or older] [or] [you are choosing the {\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].
2. [If you are the spouse[ or domestic partner] [or other family member] of an eligible, actively-at-work {employee} applying during the {employee's} [automatic acceptance] enrollment period [as described in Item 1 above] or within {XX} days of first becoming eligible, [and you **are not** choosing the {\$XXX DMB or {10-year/20-year/Unlimited} LMB or Shared Care Benefit] [and you are not issue age 70 or older,] please complete and submit the enclosed **Streamlined Application.**]
3. [If you are [an eligible, actively-at-work {employee} issue age 70 or older, or you are] choosing the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], please fill in all sections of this application.  
**Please note:** If you are an actively-at-work {employee} in a group as described in Item 1 above, and you are declined for the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], you will be automatically enrolled into the plan at the next highest [DMB] [and/or] [LMB] available[, as long-as you answer "NO" to every question in Section 1 below]. [If you are a [spouse[ or domestic partner] or other family member] as described in Item 2 above, and you are declined for the {\$XXX DMB] [and/or] [{10-year/20-year/Unlimited} LMB], you will be automatically enrolled into the plan at the next highest [DMB] [and/or] [LMB] available, as long-as you answer "NO" to every question in Section 1 below.]
4. [If you are choosing the Shared Care Benefit, please fill in all sections of this application. You and your spouse[ or domestic partner] must each complete an application; choose all of the same benefit options [(e.g.: Daily Maximum Benefit (DMB), Lifetime Maximum Benefit (LMB), Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit), and Inflation Provision)]; **and submit your applications together.**  
**Please note:** If you are an actively-at-work {employee} in a group as described in Item 1 above, and you or your spouse[ or domestic partner] is declined for coverage, you will be automatically enrolled into the plan with the coverage you choose on this application (without the Shared Care Benefit)[, as long-as you answer "NO" to every question in Section 1 below]. [If you are a [spouse[ or domestic partner]] as described in Item 2 above, and you or the actively-at-work employee is declined for coverage, you will be automatically enrolled into the plan with the coverage you choose on this application (without the Shared Care Benefit), as long-as you answer "NO" to every question in Section 1 below.]
5. All [other] first-time applicants must complete their own application and fill in all sections. An application that is not completed properly will cause a delay in processing by John Hancock.

## Instructions for currently insured applicants who want to change coverage[\*]

### [(If 1 plan design)

1. If you would like to **increase** your coverage, please fill in all sections of this application. An increase in coverage can be the purchase of a higher Daily Maximum Benefit (DMB)[, higher Lifetime Maximum Benefit (LMB) or adding an optional benefit].  
**[Please note:** If you wish to choose the Shared Care Benefit, please refer to Item {4} above.]
2. If you would like to **decrease** your coverage, please fill in Sections 2, 3 and 5 (Agreement & Acknowledgement) only. A decrease in coverage can be choosing a lower DMB [or LMB or removing an optional benefit from your coverage].
3. If you would like to do both (increase a portion of your coverage and decrease another), please fill in all sections.

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]]

### [(OR if 2+ plan designs – ongoing upgrades)

1. If you have coverage under the group long-term care insurance plan originally offered by {ABC Company} insured through John Hancock and would like to:
  - replace that coverage with this newly offered coverage, please fill in all sections of this application. If you are approved for this coverage, you will relinquish all rights and benefits of your current coverage for the rights and benefits of your new coverage.
  - make changes to your current coverage (and not apply for this newly offered coverage), please call John Hancock at {1-800-xxx-xxxx} for your application.
2. If you already have coverage under this newly offered group long-term care insurance plan insured through John Hancock and would like to:
  - increase your coverage (e.g., purchase a higher Daily Maximum Benefit (DMB) [or add an optional benefit]), please fill in all sections.
  - decrease your coverage (e.g., choosing a lower DMB), please fill in Sections 2, 3 and 5 (Agreement & Acknowledgement) only.
  - do both (increase a portion of your coverage and decrease another), please fill in all sections.

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[\*Please note: If you want to **keep** your current coverage under the plan originally offered by {ABC Company} insured through John Hancock **and apply** for this newly offered coverage, please fill in all sections.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

## Instructions for applicants who want to reinstate coverage

If you have already contacted John Hancock regarding your reinstatement of coverage and would like to apply, please fill in all sections of this application.

**Please sign and date the application where indicated. Return in the enclosed postage-paid envelope to John Hancock Service Office:**

**John Hancock Life & Health Insurance Company, {Group Long-Term Care Department, B-6,  
John Hancock Place, P.O. Box 111, Boston, Massachusetts 02117-9939}**

*[If you are a resident of {XX}, please call 1-800-XXX-XXXX for your application.]*

If you have any questions or would like more applications, please call the John Hancock Long-Term Care Customer Service Center toll-free at **1-800-XXX-XXXX**. Outside the United States, the number is {(617) 572-0048}. The TTY number for the hearing impaired is 1-800-255-1808. You can also visit our Long-Term Care Web site at [www.jhancock.com/gltc](http://www.jhancock.com/gltc), or email us at [gltc@jhancock.com](mailto:gltc@jhancock.com).

**Please note:** You must meet all eligibility requirements (as described in the Plan Summary) in order for this coverage to go into effect.

**[ABC Company] – Group Number {XXX}**

## SECTION 1: ANSWER THESE QUESTIONS FIRST

**Please check "YES" or "NO" beside each question:**

**1. Within the past 7 years, have you received: medical advice; diagnosis; or treatment from a member of the medical profession for:**

- Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or Human Immunodeficiency Virus (HIV)
- Alzheimer's Disease, Cognitive Impairment, Dementia, or Memory Loss ■ Amyotrophic Lateral Sclerosis ■ Cerebral Atrophy
- Cirrhosis ■ Crest ■ Cystic Fibrosis ■ Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney
- Huntington's Chorea ■ Kidney Disease ■ Mental Retardation ■ Metastatic Cancer ■ Mixed Connective Tissue Disease
- Multiple Myeloma ■ Multiple Sclerosis ■ Possible Multiple Sclerosis ■ Muscular Dystrophy ■ Myasthenia Gravis
- Neurological conditions affecting the brain or spinal cord ■ Parkinson's Disease ■ Polyneuropathy ■ Post-Polio Paralytic Syndrome
- Schizophrenia ■ Scleroderma ■ Spinal Cord Injury ■ Stroke/CVA ■ Systemic Lupus Erythematosus
- Transient Ischemic Attacks (2 or more)?.....

**Yes No**

**2. Do you require human assistance or supervision in any of the following activities:**

- eating ■ dressing ■ toileting ■ transferring from bed to chair ■ walking ■ maintaining continence ■ bathing?.....

**3. Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home; assisted care living facility or other custodial facility; or are you currently receiving home health care services or attending adult day care? .....**

**4. Do you currently use any of the following medical devices:**

- wheelchair ■ walker ■ hospital bed ■ quad cane ■ oxygen ■ stairlift ■ dialysis?.....

**5. Are you currently receiving Social Security Disability; Worker's Compensation; or Long-Term Disability Benefits? .....**



**If you answered "YES" to any of questions 1 – 5 above, we suggest that you do not submit an application; we will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue. [Please note: John Hancock's final underwriting decision will be based on a full underwriting evaluation of your medical history.]**

**[\$XXX DMB] [and/or] [(10-year/20-year/Unlimited) LMB] Applicants Please Note:** If you are an actively-at-work {employee} [of ABC Company] in a group as described in Item 1 of the "Instructions," and you answered "YES" to any of questions 1 – 5 above, you are eligible to receive automatic acceptance into the plan **with a lower [DMB] [and] [LMB] amount.** Please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance.**

**[Shared Care Benefit Applicants Please Note:** If you are an actively-at-work {employee} [of ABC Company] in a group as described in Item 1 of the "Instructions," and you answered "YES" to any of questions 1 – 5 above, you are eligible to receive automatic acceptance into the plan **without the Shared Care Benefit.** Please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance.** [If you are the spouse[ or domestic partner] as described in Item 2 of the "Instructions," and the actively-at-work employee answered "YES" to any of questions 1 – 5 above, you are eligible to receive streamlined underwriting into the plan **without the Shared Care Benefit.** Please complete and submit the enclosed **Application B.**]

## SECTION 2: APPLICANT INFORMATION (PLEASE PRINT)

<input type="text"/>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="text"/>	<input type="checkbox"/> Male
<b>1. Last Name</b>	<input type="checkbox"/> Ms. <input type="checkbox"/> Miss	<b>First Name</b>	<input type="checkbox"/> Female
<input type="text"/>	<input type="checkbox"/> Other _____	<b>M.I.</b>	<b>2. Gender</b>
<input type="text"/>		<input type="text"/>	
<b>[3. Social Security Number]</b>		<b>[4.] Street Address</b>	

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**



[(If Upgrade – ongoing)

**8. Please check one:**

**Option 1:**  I choose to **replace** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} with this coverage.

**Option 2:**  I choose to **keep** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} **and apply** for this coverage.]

**9. Please choose your desired coverage type:**  Facilities Only Coverage **OR**  Comprehensive Long-Term Care Coverage ]

**10. Please choose your desired benefit.** **OR** **10. Please choose your desired Daily Maximum Benefit (DMB).**

Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)

DMB:  {\$100}  {\$200}  {\$300} ]

Option 1:  {\$100/\$182,500}

**11. Please choose your desired Lifetime Maximum Benefit (LMB). (Note: If you are choosing the Shared Care Benefit, you must choose the {5-year} LMB.)**

Option 2:  {\$200/\$365,000}

Option 3:  {\$300/\$547,500} ]

LMB:  {2-year}  {5-year}  {Unlimited} ]

[(OR if Employer-Paid is offered)

**10a. If you are an Active Employee, please choose your desired benefit from the list below:**

Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)

Option 1:  {\$100/\$182,500} {(Core \$100 DMB; 5-year LMB)}

Option 2:  {\$150/\$273,750} {(Core \$100 DMB + \$50; 5-year LMB)}

Option 3:  {\$200/\$365,000} {(Core \$100 DMB + \$100; 5-year LMB)}

Option 4:  {\$300/\$547,500} {(Core \$100 DMB + \$200; 5-year LMB)}

**10b. If you are (a/an) [Member of the Board of Directors,] [Eligible Retiree] [or] [Eligible Family Member], please choose your desired benefit from the list below:**

Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)

Option 1:  {\$100/\$182,500}

Option 2:  {\$150/\$273,750}

Option 3:  {\$200/\$365,000}

Option 4:  {\$300/\$547,500} ]

[(11). Please choose your desired Qualification Period:  {60-day}  {90-day} ]

[(12). Do you wish to choose the Return of Premium at Death Benefit?  Yes  No]

[(13). Do you wish to choose the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit)?

Yes, I elect this benefit.

No, I have reviewed the Outline of Coverage and Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit) as described therein. Specifically, I have reviewed the plan and reject the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit).]

[(14). Please choose your desired Inflation Provision. (Please check one.)

Future Purchase Option (FPO)

Automatic Benefit Increase (ABI)

Automatic Consumer Price Index (ACPI) ]

[(15). Do you wish to choose the [Accelerated Payment Option OR Ten-Year Payment Option]?  Yes  No

(Note: You must have chosen [ABI] [or] [ACPI] in order to choose this option.)]

**[Shared Care Benefit]**

**16. Do you wish to choose the Shared Care Benefit?  Yes  No**

**[(Note: You must have chosen the {5-year} LMB in order to choose the Shared Care Benefit.)]**

If you checked "YES," please provide the following information about your spouse[ or domestic partner]. Both you and your spouse[ or domestic partner] must apply for the Shared Care Benefit; choose all of the same benefits options [(e.g.: DMB, LMB, Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit), and Inflation Provision)]; **and submit your applications together.** If your benefit choices are different or your applications are not submitted together, it will cause a delay in processing by John Hancock.

If you checked "NO," please [continue].

Spouse's[ or Domestic Partner's] Last Name

Spouse's[ or Domestic Partner's] First Name

If you are a Spouse [or Domestic Partner] of an {Active Employee}, please complete {16a}. All others, please complete {16b}.

[16a. Employee ID of (Active Employee)           ]

[16b.] Spouse's [ or Domestic Partner's ] Social Security Number:    -   -     ]

### SECTION 4: STATEMENT OF HEALTH

**PLEASE ANSWER ALL QUESTIONS (#1 - #9) – CONTINUED ON THE NEXT PAGE**

**1. What is your height?** \_\_\_\_\_ **What is your weight?** \_\_\_\_\_

**2. Have you used tobacco products in the past 12 months? This means: cigarettes; pipe; cigar; or chewing tobacco. ....**  **Yes**  **No**

**3. Have you consulted with your primary care physician or a specialist within the past 24 months? .....**  **Yes**  **No**

Primary Care Physician's or Specialist's Name \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

**4. Have you been prescribed or have you taken prescription medications at any time over the past 18 months? .....**  **Yes**  **No**

If yes, please list each medication below.

Name of Medication	Dosage	Frequency	Reason Prescribed	Name of Physician

**5. Within the past 7 years, have you received: medical advice; diagnosis; or treatment from, or consulted with a member of the medical profession for any of the following conditions?**

- a. **Circulatory Disorders:**
  - Transient Ischemic Attack ■ Amaurosis Fugax ■ Heart Arrhythmias ■ Valvular Disease ■ Cardiomyopathy
  - Congestive Heart Failure ■ Aneurysm ■ Coronary Artery Disease ■ High Blood Pressure  **Yes**  **No**
  - Peripheral Vascular Disease ■ Carotid Artery Disease ■ Embolisms.....  **No**
- b. **Endocrine & Pituitary Disorders:**
  - Diabetes ■ Addison's Disease ■ Pancreatitis ■ Cushing's Disease.....  **Yes**  **No**
- c. **Cancers:**
  - Leukemia ■ Lymphoma ■ Tumors ■ Melanoma ■ Squamous Cell ■ Sarcomas.....  **Yes**  **No**
- d. **Genitourinary Disorders:**
  - Renal Insufficiency ■ Incontinence ■ Prostate Disorders ■ Bladder Disorders.....  **Yes**  **No**
- e. **Gastrointestinal Disorders:**
  - Hepatitis ■ Ulcerative Colitis ■ Crohn's Disease ■ Liver Disorders.....  **Yes**  **No**
- f. **Neurological Disorders:**
  - Mental Illness ■ Depression ■ Seizures ■ Tremors ■ Neuropathy ■ Syncope ■ Anxiety ■ Chronic Fatigue Syndrome.....  **Yes**  **No**
- g. **Blood Disorders:**
  - Anemia ■ Polycythemia Vera ■ Thrombocytopenia ■ Hemachromatosis ■ Leukopenia .....  **Yes**  **No**
- h. **Musculoskeletal Disorders:**
  - Osteoporosis ■ Arthritis ■ Rheumatoid Arthritis ■ Osteoarthritis ■ Fractures ■ Fibromyalgia ■ Degenerative Joint Disease
  - Scoliosis ■ Spinal Stenosis ■ Lupus ■ Polymyalgia Rheumatica ■ Osteopenia ■ Paralysis .....  **Yes**  **No**
- i. **Respiratory Disorders:**
  - Emphysema ■ Bronchitis ■ Asthma ■ Bronchiectasis ■ Asbestosis ■ Sarcoidosis
  - Chronic Obstructive Pulmonary Disease ■ Pulmonary Fibrosis.....  **Yes**  **No**
- j. **Eye & Ear Disorders:**
  - Macular Degeneration ■ Glaucoma ■ Retinitis Pigmentosa ■ Labrynthitis ■ Meniere's/Vertigo.....  **Yes**  **No**

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX.}**

k. **Substance Abuse:**  
 ■ Alcoholism ■ Drug dependency ■ Illicit drug use .....

6. **Within the past 7 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?** .....

7. **Within the past 7 years has any surgery or medical test(s) been recommended that have not been performed?**.....

8. **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, please list medical reason: \_\_\_\_\_

9. **Have any of your family members (mother, father, siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions:**

■ Alzheimer’s Disease ■ Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease) ■ Dementia ■ Diabetes ■ Heart Disease **Yes** **No**  
 ■ Huntington’s Disease ■ Parkinson’s Disease ■ Stroke? .....

Diagnosis	Relationship (eg. Mother)	Age of Onset

**If you answered “YES” to any of the questions 4 – 8 above regarding your health history, provide full details below. If additional space is needed, please attach a separate sheet.**

Questions (#4 - #8)	Diagnosis, Disorder and/or Reason	Diagnosis Date	Treatment Date	Include Name, Address, Telephone Number of Physician, Provider and/or Insurer (if applicable) and Explanation or Comments

**Summary Notice of Information Practices**  
 In connection with your application for coverage, we may collect personal information from other sources in an effort to confirm, clarify, or supplement the personal information you have supplied on your application. The personal information that we collect may, in certain circumstances, be disclosed to third parties without authorization as permissible by law. You have right of access and correction with respect to all personal information collected. The Notice of Information Practices will be furnished to you upon request.



**Please make sure you answered all questions (#1 - #9) in the Statement of Health Before Proceeding**

## SECTION 5: AGREEMENT & ACKNOWLEDGEMENT

**Agreement** – I hereby apply for the Group Long-Term Care Insurance offered under the group insurance policy issued by John Hancock Life & Health Insurance Company to [ABC Company] (policyholder), and hereby represent and agree that the foregoing statements, together with any explanations contained in this application, are to the best of my knowledge and belief, true and complete; are statements of fact and not opinion; and shall be the basis for issuance of insurance for which I am now applying.

Neither [ABC Company], nor any agent or representative acting on behalf of John Hancock is authorized to make or discharge contracts; waive, alter, modify, or change any of the conditions or provisions of any application or policy; or to accept risks or pass on insurability.

**Applicable to currently insured applicants who want to change their coverage as described in the “Instructions”** – If approved, I understand that I am relinquishing all rights and benefits of my current coverage and replacing them with the rights and benefits of the new coverage.

**[(If Upgrade/Transfer – initial) Applicable to applicants who apply to replace their current coverage]** – If coverage under the new plan is issued to me, I understand that I am relinquishing all rights and benefits of my current coverage under the existing [former carrier] Group Long-Term Care Insurance Plan for [ABC Company] and replacing them with the rights and benefits in the new {ABC Company} Group Long-Term Care Insurance Plan insured through John Hancock.]

**Acknowledgement** – I have received and reviewed: the Outline of Coverage; Shopper’s Guide to Long-Term Care Insurance; Notice of Protected Health Information Privacy Practices; Suitability Form (or Personal Worksheet); and Potential Rate Increase Disclosure Form before completing my application.

**Caution** – If your answers on this application are incorrect or untrue, John Hancock may have the right to deny benefits or rescind your coverage. Please refer to the last page of this application for important notices.



Applicant’s Signature

Date

**Notice: You are required to notify John Hancock of any change in your health that occurs while your application is being reviewed.**

## SECTION 6: AUTHORIZATION

**This Authorization is intended to comply with HIPAA.** “HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all the following information:
  - my medical records and medical history; and
  - other information that relates to:
    - the diagnosis of any physical or mental condition; or
    - the treatment or prognosis of any physical or mental condition,whether such information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life & Health Insurance Company (John Hancock)); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.
3. Health information about me may be disclosed to John Hancock and its affiliates; service providers; reinsurers; agents and representatives; and to any consumer reporting agency such as the MIB.
4. Health information about me may be used or disclosed: in connection with my application; to service my long-term care insurance coverage; and to evaluate any claim for long-term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.

5. I understand that:

- If I do not sign this Authorization, John Hancock may:
  - decline to issue long-term care insurance coverage to me; and
  - decline to pay any claim for such benefits.
- This Authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I understand that I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
- My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
- A copy of this Authorization is as valid as the original.
- I will receive a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.



\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Name (Please Print)

\_\_\_\_\_  
Date

If this Authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included: \_\_\_\_\_

### SECTION 7: INSURANCE HISTORY – PLEASE ANSWER ALL QUESTIONS (#1 - #4)

**STATE LAW REQUIRES THAT WE ASK YOU THE FOLLOWING QUESTIONS. ALL APPLICANTS MUST COMPLETE THIS SECTION IN ORDER TO APPLY FOR COVERAGE. IF YOU DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

1. Do you have another long-term care policy or certificate in force (including health care service contract, health maintenance organization contract)?.....  Yes  No
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?.....  Yes  No  
 If so, with which company? \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 If that coverage lapsed, when did it lapse? \_\_\_\_\_
3. Are you currently covered by Medicaid? .....  Yes  No
4. Do you intend to replace any of your medical or health insurance coverage with this certificate? .....  Yes  No



## PROTECTION AGAINST UNINTENDED LAPSE

**IF YOU [CHOSE AUTOMATIC BANK WITHDRAWAL, DIRECT BILLING OR CREDIT/DEBIT CARD AND] DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

I choose NOT to name a person to receive this notice.  \_\_\_\_\_  
**Applicant's Signature** **Date**

If you choose to name another person to receive notice of termination, please provide name and address below. (Please print legibly.)

Yes, I am interested in naming the following person to receive this notice.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

## CHECKLIST

**Please make sure you remember to:**

- Answer all questions within each section**
- Sign and date wherever you see a  (where applicable)**
- Tear off and return each page to John Hancock**

**An application that is not completed properly will cause a delay in processing by John Hancock.**

## IMPORTANT NOTICES

**[ARKANSAS, LOUISIANA, and NEW MEXICO RESIDENTS – 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.]

**[CALIFORNIA RESIDENTS –** The certificate is an approved long-term care insurance certificate under California law and regulations. However, the benefits payable by the certificate will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care. For information about policies qualifying under the California Partnership for Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number of 1-800-434-0222.]

**[COLORADO RESIDENTS – Fraud Notice:** 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 for the purpose of defrauding or attempting to defraud the 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 RESIDENTS – 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.]

**[FLORIDA RESIDENTS –** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[HAWAII RESIDENTS –** THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.]

**[ILLINOIS RESIDENTS –** THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED TRADITIONAL LONG-TERM CARE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.]

**[INDIANA RESIDENTS – This certificate does not qualify for Medicaid asset protection under the Indiana Long-Term Care Program. However, this certificate is an approved long-term care insurance certificate under state insurance regulations. For information about policies qualifying under the Indiana Long-Term Care Program, call the Senior Health Insurance Information Program of the Department of Insurance at 1-800-452-4800.]**

**[IOWA RESIDENTS –** THIS CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG-TERM CARE INSURANCE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.]

**[KENTUCKY RESIDENTS –** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[LOUISIANA RESIDENTS – 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.]

**[MAINE, TENNESSEE, VIRGINIA and WASHINGTON RESIDENTS –** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]

**[MICHIGAN RESIDENTS –** For additional information about long-term care coverage, write to the Michigan Insurance Bureau, P.O. Box 30220, Lansing, MI 48909, or call the Area Agency on Aging in your community. ]

**[NEW JERSEY RESIDENTS** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[NEW YORK RESIDENTS** – 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[OHIO RESIDENTS – Fraud Notice:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**[OKLAHOMA RESIDENTS – 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.]

**[OREGON RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.]

**[PENNSYLVANIA RESIDENTS – Fraud Notice:** 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

**[VERMONT RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

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

***STATEMENT OF VARIABILITY – This page will be revised as additional state notices are added or existing state notices are revised.***

# STREAMLINED APPLICATION FOR INSURANCE UNDER [THE ABC COMPANY] GROUP LONG-TERM CARE INSURANCE PLAN

Underwritten by John Hancock Life & Health Insurance Company (John Hancock), Boston, MA 02117

Group Number: {XXX}  
Form B

## Instructions for first-time applicants

- { [1. If you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit [or are issue age [70] or older]], please complete and submit the enclosed **Application**.]
- [2] [If you are:
- An eligible, actively-at-work {employee} [enrolling/applying] during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - A newly hired eligible or newly eligible, actively-at-work {employee} [enrolling/applying] within {XX} days of first becoming eligible; or ]
  - An {employee} who was on a leave of absence or disability during the designated {XXXX} enrollment period [enrolling/applying] within {XX} days of returning to work on a regular basis;
- please complete and submit the enclosed **{Employee} Enrollment Form for Automatic Acceptance** [unless you are [issue age 70 or older] [or] [you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].]
- [3]. [If you are:
- [A spouse[ or domestic partner] or other family member of] **OR** [a/An eligible, actively-at-work {employee}] [or his/her spouse[ or domestic partner] or other family member] applying during the designated {XXXX} enrollment period (mm/dd/yy – mm/dd/yy); ]
  - [A spouse[ or domestic partner] or other family member of] **OR** [a/An eligible, actively-at-work {employee}] [or his/her spouse[ or domestic partner] or other family member] applying within {XX} days of first becoming eligible; or
  - [A spouse[ or domestic partner] or other family member of] **OR** [a/An {employee}] who was on a leave of absence or disability during the designated {XXXX} enrollment period [or his/her spouse[ or domestic partner] or other family member] applying within {XX} days of [the employee's] [returning/return] to work on a regular basis.];
- [Please complete and submit this **Streamlined Application** [unless you are [issue age 70 or older] [or] [you are choosing the [\$XXX Daily Maximum Benefit (DMB) or {10-year/20-year/Unlimited} Lifetime Maximum Benefit (LMB) or Shared Care Benefit]].]
- [4]. All other applicants {including actively-at-work employees issue age [70] or older} , please complete and submit the enclosed **Application**. An application that is not completed properly will cause a delay in processing by John Hancock.

## Instructions for currently insured applicants who want to change coverage[\*]

### [(If 1 plan design)

1. If you would like to **increase** your coverage, please {complete and submit the enclosed **Application**.} An increase in coverage can be the purchase of a higher Daily Maximum Benefit (DMB)[, higher Lifetime Maximum Benefit (LMB) or adding an optional benefit].
2. If you would like to **decrease** your coverage, please fill in Sections 2, 3 and 4 (Agreement & Acknowledgement) only. A decrease in coverage can be choosing a lower DMB [or LMB or removing an optional benefit from your coverage].
3. If you would like to do both (increase a portion of your coverage and decrease another), please {complete and submit the enclosed **Application A** or fill in all sections.}

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]

### [(OR if 2+ plan designs – ongoing upgrades)

1. If you have coverage under the group long-term care insurance plan originally offered by {ABC Company} insured through John Hancock and would like to:
  - replace that coverage with this newly offered coverage, please {complete and submit the enclosed **Application** }.
  - make changes to your current coverage (and not apply for this newly offered coverage), please call John Hancock at {1-800-xxx-xxxx} for your application.
2. If you already have coverage under this newly offered group long-term care insurance plan insured through John Hancock and would like to:
  - increase your coverage (e.g., purchase a higher Daily Maximum Benefit (DMB) [or add an optional benefit]), please {complete and submit the enclosed **Application A**.}
  - decrease your coverage (e.g., choosing a lower DMB), please fill in Sections 2, 3 and 4 (Agreement & Acknowledgement) only.
  - do both (increase a portion of your coverage and decrease another), please {complete and submit the enclosed **Application A**.}

[Except for changes to your DMB only, any approved change will result in your relinquishing all rights and benefits of your current coverage for the rights and benefits of your new coverage.]

[\*Please note: If you want to **keep** your current coverage under the plan originally offered by {ABC Company} insured through John Hancock **and** **apply** for this newly offered coverage, please {complete and submit the enclosed **Application**.]

[Please refer to the enclosed enrollment materials for a description of the optional benefit(s).]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}**

**Please sign and date the application where indicated. Return in the enclosed postage-paid envelope to John Hancock Service Office:**

**John Hancock Life & Health Insurance Company, {Group Long-Term Care Department, B-6, John Hancock Place, P.O. Box 111, Boston, Massachusetts 02117-9939}**

*[If you are a resident of {XX}, please call 1-800-XXX-XXXX for your application.]*

{If you have any questions or would like more applications, please call the John Hancock Long-Term Care Customer Service Center toll-free at **1-800-XXX-XXXX**. Outside the United States, the number is {(617) 572-0048}. The TTY number for the hearing impaired is 1-800-255-1808. You can also visit our Long-Term Care Web site at [www.jhancock.com/gltc](http://www.jhancock.com/gltc), or email us at [gltc@jhancock.com](mailto:gltc@jhancock.com).}

**Please note:** You must meet all eligibility requirements (as described in the Plan Summary) in order for this coverage to go into effect.

## SECTION 1: ANSWER THESE QUESTIONS FIRST

**Please check "YES" or "NO" beside each question:**

1. **Within the past 7 years, have you received: medical advice; diagnosis; or treatment from a member of the medical profession for:**
  - Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or Human Immunodeficiency Virus (HIV)
  - Alzheimer's Disease, Cognitive Impairment, Dementia, or Memory Loss ■ Amyotrophic Lateral Sclerosis ■ Cerebral Atrophy
  - Cirrhosis ■ Crest ■ Cystic Fibrosis ■ Diabetes treated with insulin or with amputation or ongoing complications that affect the kidney
  - Huntington's Chorea ■ Kidney Disease ■ Mental Retardation ■ Metastatic Cancer ■ Mixed Connective Tissue Disease
  - Multiple Myeloma ■ Multiple Sclerosis ■ Possible Multiple Sclerosis ■ Muscular Dystrophy ■ Myasthenia Gravis
  - Neurological conditions affecting the brain or spinal cord ■ Parkinson's Disease ■ Polyneuropathy ■ Post-Polio Paralytic Syndrome
  - Schizophrenia ■ Scleroderma ■ Spinal Cord Injury ■ Stroke/CVA ■ Systemic Lupus Erythematosus
  - Transient Ischemic Attacks (2 or more)?..... Yes No
2. **Do you require human assistance or supervision in any of the following activities:**
  - eating ■ dressing ■ toileting ■ transferring from bed to chair ■ walking ■ maintaining continence ■ bathing?..... □ □
3. **Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home; assisted care living facility or other custodial facility; or are you currently receiving home health care services or attending adult day care? .....** □ □
4. **Do you currently use any of the following medical devices:**
  - wheelchair ■ walker ■ hospital bed ■ quad cane ■ oxygen ■ stairlift ■ dialysis?..... □ □
5. **Are you currently receiving Social Security Disability; Worker's Compensation; or Long-Term Disability Benefits? .....** □ □



**If you answered "YES" to any of questions 1 – 5 above, we suggest that you do not submit an application; we will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue.**

[ABC Company] – Group Number {XXX}

## SECTION 2: APPLICANT INFORMATION (PLEASE PRINT)

<p>1. Last Name</p> <p>[3.] Social Security Number</p> <p>City/Town</p> <p>[5.] Home Phone</p> <p>[8.] Email Address (optional)</p>	<p>[4.] Street Address</p> <p>State[/Territory]</p> <p>[6.] Work Phone</p> <p>7. Date of Birth</p>	<p>First Name</p> <p>M.I.</p> <p>2. Gender</p> <p>Month Day Year</p>
<div style="border: 1px solid black; padding: 5px; display: inline-block;">             This box is used only when enrolling with Employee ID.         </div>		
<div style="background-color: #cccccc; padding: 5px; display: inline-block; font-weight: bold;">             THIS BOX FOR INTERNAL USE ONLY         </div>		

## SECTION 3: GENERAL INFORMATION

### 1. Which term applies to you? (Please check one.)

- |   |  |
|---|--|
| <input type="checkbox"/> Active Employee*   | <input type="checkbox"/> Member of the Board of Directors]   |
| <input type="checkbox"/> Spouse of {Active Employee*}]  | <input type="checkbox"/> Spouse of Member of the Board of Directors]   |
| <input type="checkbox"/> Domestic Partner of {Active Employee*}]  | <input type="checkbox"/> Domestic Partner of Member of the Board of Directors]   |
| <input type="checkbox"/> Surviving Spouse of {Employee}]  | <input type="checkbox"/> Eligible Retiree]   |
| <input type="checkbox"/> Parent or Parent-in-Law of {Active Employee*}]   | <input type="checkbox"/> Spouse of Eligible Retiree]   |
| <input type="checkbox"/> Sibling/Spouse of Sibling of {Active Employee*} or of<br>{Active Employee's} Spouse[ or Domestic Partner]]         | <input type="checkbox"/> Domestic Partner of Eligible Retiree]   |
| <input type="checkbox"/> Adult Child/Spouse of Adult Child of {Active Employee*} or of<br>{Active Employee's} Spouse[ or Domestic Partner]] | <input type="checkbox"/> Surviving Spouse of Retiree]  |
| <input type="checkbox"/> Grandparent or Grandparent-in-Law of {Active Employee*}]   | <input type="checkbox"/> Parent or Parent-in-Law of Eligible Retiree]  |
|   | <input type="checkbox"/> Sibling/Spouse of Sibling of Eligible Retiree or of<br>Eligible Retiree's Spouse[ or Domestic Partner]]         |
|   | <input type="checkbox"/> Adult Child/Spouse of Adult Child of Eligible Retiree or of<br>Eligible Retiree's Spouse[ or Domestic Partner]] |
|   | <input type="checkbox"/> Grandparent or Grandparent-in-Law of Eligible Retiree]  |

{\*Active Employee means an eligible employee who is actively at work. An employee on a leave of absence or disability is not considered an Active Employee for purposes of this enrollment.}

### 2. Are you married[ or in a committed relationship with a domestic partner]? Yes No

**Note: If you checked {Active Employee}, please skip to question {4 or 5}. If you checked [Member of the Board of Directors, Eligible Retiree or Surviving Spouse], please skip to question {8}. All others go to question {3}.**

### 3. Name of {Active Employee or Eligible Retiree or Member of the Board of Directors} through whom you are applying for coverage:

Last Name       First Name       M.I.      ]
 Employee ID field & corresponding box.

### 4. [Social Security Number/Employee ID] of {Active Employee or

Eligible Retiree or Member of the Board of Directors]  -  -  **OR**  ]  
 [(leading zeroes NOT required)]:

THIS BOX FOR INTERNAL USE ONLY

### 5. If the {Active Employee} was on a leave of absence or disability during the designated {XXXX} enrollment period

(mm/dd/yy – mm/dd/yy), when did the leave/disability begin?  
 and end?             ]  
 Month Day Year      Month Day Year

### 6. {Active Employee's} hire/eligibility date:

]  
 Month Day Year

### 7. Print name of {Active Employee's} [ABC Company] below. If you are not sure of the company name, please review the enclosed company list (Example: [ABC Company]): \_\_\_\_\_

## BENEFIT OPTIONS (explanations of these provisions are in the enclosed enrollment materials)

[(If Upgrade/Transfer - initial)

### 8. Please check one:

**Option 1:**  I choose to **replace** my current coverage under the existing [{former carrier}] Group Long-Term Care Insurance Plan for {ABC Company} with this coverage.

**Option 2:**  I choose to **keep** my current coverage under the existing [{former carrier}] Group Long-Term Care Insurance Plan for {ABC Company} **and apply** for this coverage.]

[(If Upgrade – ongoing)

### 8. Please check one:

**Option 1:**  I choose to **replace** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} with this coverage.

**Option 2:**  I choose to **keep** my current coverage under the Group Long-Term Care Insurance Plan originally offered by {ABC Company} **and apply** for this coverage.]

### 9. Please choose your desired coverage type: Facilities Only Coverage **OR** Comprehensive Long-Term Care Coverage ]

IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}

**[10. Please choose your desired benefit.**

Daily Maximum Benefit (DMB)/  
Lifetime Maximum Benefit (LMB)

- Option 1:  { \$100/\$182,500 }
- Option 2:  { \$200/\$365,000 }
- Option 3:  { \$300/\$547,500 }

**OR [10. Please choose your desired Daily Maximum Benefit (DMB).**

DMB:  [\$100]  [\$200]  [\$300] ]

**[11. Please choose your desired Lifetime Maximum Benefit (LMB).**

LMB:  [2-year]  [5-year] ]

**[[11]. [Please choose your desired Qualification Period:  {60-day}  {90-day} ]**

**[[12]. [Do you wish to choose the Return of Premium at Death Benefit?  Yes  No]**

**[[13]. [Do you wish to choose the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit)?**

- Yes**, I elect this benefit.
- No**, I have reviewed the Outline of Coverage and Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit) as described therein. Specifically, I have reviewed the plan and reject the Reduced Lifetime Maximum Benefit (Nonforfeiture Benefit).]

**[[14]. [Please choose your desired Inflation Provision. (Please check one.)**

- Future Purchase Option (FPO)  Automatic Benefit Increase (ABI)  Automatic Consumer Price Index (ACPI) ]

**[[15]. [Do you wish to choose the [Accelerated Payment Option OR Ten-Year Payment Option]?  Yes  No  
(Note: You must have chosen [ABI] [or] [ACPI] in order to choose this option.)]**

## **SECTION 4: AGREEMENT & ACKNOWLEDGEMENT – PLEASE SIGN AND DATE BELOW**

**Agreement** – I hereby apply for the Group Long-Term Care Insurance offered under the group insurance policy issued by John Hancock Life & Health Insurance Company to [ABC Company] (policyholder), and hereby represent and agree that the foregoing statements, together with any explanations contained in this application, are to the best of my knowledge and belief, true and complete; are statements of fact and not opinion; and shall be the basis for issuance of insurance for which I am now applying.

Neither [ABC Company], nor any agent or representative acting on behalf of John Hancock is authorized to make or discharge contracts; waive, alter, modify, or change any of the conditions or provisions of any application or policy; or to accept risks or pass on insurability.

**Applicable to currently insured applicants who want to change their coverage as described in the “Instructions”** – If approved, I understand that I am relinquishing all rights and benefits of my current coverage and replacing them with the rights and benefits of the new coverage.]

**[(If Upgrade/Transfer – initial) Applicable to applicants who apply to replace their current coverage** – If coverage under the new plan is issued to me, I understand that I am relinquishing all rights and benefits of my current coverage under the existing [former carrier] Group Long-Term Care Insurance Plan for [ABC Company] and replacing them with the rights and benefits in the new [ABC Company] Group Long-Term Care Insurance Plan insured through John Hancock.]

**Acknowledgement** – I have received and reviewed: the Outline of Coverage; Shopper’s Guide to Long-Term Care Insurance; Notice of Protected Health Information Privacy Practices; Suitability Form (or Personal Worksheet); and Potential Rate Increase Disclosure Form before completing my application.

**Caution** – If your answers on this application are incorrect or untrue, John Hancock may have the right to deny benefits or rescind your coverage. Please refer to the last page of this application for important notices.



\_\_\_\_\_  
**Applicant’s Signature**

\_\_\_\_\_  
**Date**

**Notice: You are required to notify John Hancock of any change in your health that occurs while your application is being reviewed.**

## SECTION 5: INSURANCE HISTORY – PLEASE ANSWER ALL QUESTIONS (#1 - #4)

**STATE LAW REQUIRES THAT WE ASK YOU THE FOLLOWING QUESTIONS. ALL APPLICANTS MUST COMPLETE THIS SECTION IN ORDER TO APPLY FOR COVERAGE. IF YOU DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

1. Do you have another long-term care policy or certificate in force (including health care service contract, health maintenance organization contract)?.....  Yes  No
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months?.....  Yes  No  
 If so, with which company? \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 If that coverage lapsed, when did it lapse? \_\_\_\_\_
3. Are you currently covered by Medicaid? .....  Yes  No
4. Do you intend to replace any of your medical or health insurance coverage with this certificate? .....  Yes  No

## SECTION 6: BILLING & PAYMENT

**[{ACTIVE EMPLOYEES'}[ AND THEIR SPOUSES'[ OR DOMESTIC PARTNERS'] premiums will be deducted from the paycheck of the eligible, actively-at-work {employee}. The {Active Employee} must sign the following Payroll Deduction Authorization (even if the [employee] does not apply with his/her spouse[ or domestic partner]):**

I hereby authorize my employer, [ABC Company], [or a participating subsidiary or affiliate,] to deduct from my salary the amount(s) necessary to make the premium contribution for the Group Long-Term Care Insurance coverage under a policy issued by John Hancock Life & Health Insurance Company to [ABC Company], in my name and/or in the name of my spouse[ or domestic partner], if applicable. This authorization may be cancelled only upon written notification to John Hancock from me or the insured.



\_\_\_\_\_ ]  
**{Active Employee's} Signature**

\_\_\_\_\_ ]  
**Date**

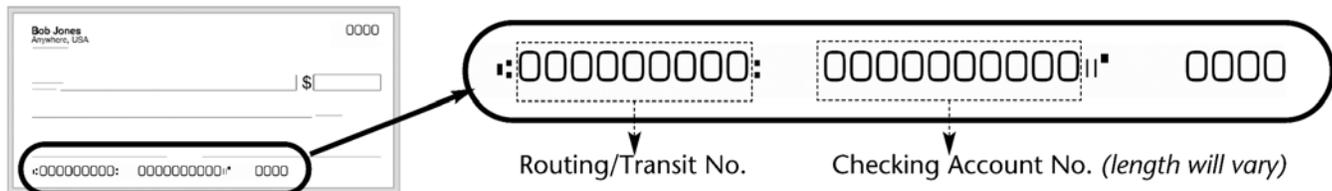
**ALL [OTHER] APPLICANTS must choose to pay premiums through [monthly automatic bank withdrawal, direct billing, or credit/debit card]. Please choose only one billing option and complete the "Protection Against Unintended Lapse" section located [on the bottom of this page]:**

- Monthly Automatic Bank Withdrawal (ABW).** Please **attach a voided check**, sign the authorization below, AND select the day of the month on which you would like your checking account withdrawn:  5<sup>th</sup> day,  15<sup>th</sup> day, **or**  25<sup>th</sup> day;
- Direct Billing.**  
**Please note:** If you would like your bill sent to an address other than your home address, please contact John Hancock at [1-800-XXX-XXXX]; **OR**
- Credit/Debit Card.** Please provide the following information and sign the authorization below:

[Payment Frequency:	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly]	
[Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa]	
Card Number: _____	Expiration Date (mm/yy): _____		
Cardholder's Name: _____			
Cardholder's Signature: _____ (if different from the applicant)			

]

**[Authorization to Honor Payment through ABW or Credit/Debit Card**



**Name of bank (and branch, if applicable)**

**Routing/Transit and Checking Account No.**

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I authorize John Hancock Life & Health Insurance Company to initiate automatic bank withdrawals from my checking account [or charge my credit/debit card] shown above in order to effect payment of my premium. Also, I authorize my bank [or credit/debit card company] to charge such account [or card] for such withdrawals [or transactions]. I understand that I will not receive any bills or notices of withdrawal [or transaction] from John Hancock. I also understand that if any withdrawal [or transaction] is not honored by my bank [or credit/debit card company] for any reason, I am responsible to pay my premium or my insurance coverage will be terminated. This authorization will remain in effect until I, my bank [or credit/debit card company], or John Hancock terminates it by giving a thirty (30) day written termination notice to the others.



**Applicant's Signature**

**Date**

**If you have a joint checking account, please have the other depositor sign below.**



**Depositor's Signature**

**Date**

]

**PROTECTION AGAINST UNINTENDED LAPSE**

**IF YOU [CHOSE AUTOMATIC BANK WITHDRAWAL, DIRECT BILLING OR CREDIT/DEBIT CARD AND] DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.**

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

I choose NOT to name a person to receive this notice.

**Applicant's Signature**

**Date**

If you choose to name another person to receive notice of termination, please provide name and address below. **(Please print legibly.)**

Yes, I am interested in naming the following person to receive this notice.

Name

Address

City

State

Zip

## CHECKLIST

**Please make sure you remember to:**

- Answer all questions within each section**
- Sign and date wherever you see a  (where applicable)**
- Tear off and return each page to John Hancock**

**An application that is not completed properly will cause a delay in processing by John Hancock.**

## IMPORTANT NOTICES

**[ARKANSAS, LOUISIANA, and NEW MEXICO RESIDENTS – 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.]

**[CALIFORNIA RESIDENTS –** The certificate is an approved long-term care insurance certificate under California law and regulations. However, the benefits payable by the certificate will not qualify for Medi-Cal asset protection under the California Partnership for Long-Term Care. For information about policies qualifying under the California Partnership for Long-Term Care, call the Health Insurance Counseling and Advocacy Program at the toll-free number of 1-800-434-0222.]

**[COLORADO RESIDENTS – Fraud Notice:** 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 for the purpose of defrauding or attempting to defraud the 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 RESIDENTS – 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.]

**[FLORIDA RESIDENTS –** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[HAWAII RESIDENTS –** THIS CONTRACT FOR LONG-TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG-TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.]

**[ILLINOIS RESIDENTS –** THIS CERTIFICATE IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED TRADITIONAL LONG-TERM CARE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES APPROVED UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966.]

**[INDIANA RESIDENTS – This certificate does not qualify for Medicaid asset protection under the Indiana Long-Term Care Program. However, this certificate is an approved long-term care insurance certificate under state insurance regulations. For information about policies qualifying under the Indiana Long-Term Care Program, call the Senior Health Insurance Information Program of the Department of Insurance at 1-800-452-4800.]**

**[IOWA RESIDENTS –** THIS CERTIFICATE DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS CERTIFICATE IS AN APPROVED LONG-TERM CARE INSURANCE CERTIFICATE UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-515-281-5705.]

**[KENTUCKY RESIDENTS –** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.]

**[LOUISIANA RESIDENTS – 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.]

**[MAINE, TENNESSEE and VIRGINIA and WASHINGTON RESIDENTS –** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

**[MICHIGAN RESIDENTS –** For additional information about long-term care coverage, write to the Michigan Insurance Bureau, P.O. Box 30220, Lansing, MI 48909, or call the Area Agency on Aging in your community.]

**IF YOU HAVE ANY QUESTIONS, PLEASE CALL JOHN HANCOCK AT {1-800-XXX-XXXX}**

**[NEW JERSEY RESIDENTS** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[NEW YORK RESIDENTS** – 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[OHIO RESIDENTS – Fraud Notice:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**[OKLAHOMA RESIDENTS – 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.]

**[OREGON RESIDENTS – WARNING:** Any person who knowingly, and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.]

**[PENNSYLVANIA RESIDENTS – Fraud Notice:** 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

**[VERMONT RESIDENTS – Fraud Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.]

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

***STATEMENT OF VARIABILITY – This page will be revised as additional state notices are added or existing state notices are revised.***

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**John Hancock Life & Health Insurance Company**

John Hancock Place  
Post Office Box 111  
Boston, Massachusetts 02117  
Phone: 888-877-6075  
Fax: (617) 572-0399  
e-mail: [nrice@jhancock.com](mailto:nrice@jhancock.com)



**Noah Rice**  
**Senior Contract Consultant**  
**LTC Contracts and Legislative Services**

May 30, 2012

Re: John Hancock Life & Health Insurance Company  
NAIC #: 93610 FEIN #: 13-3072894  
Group Long-Term Care Insurance Submission  
Forms: P-FACE(2009-12), et al.  
(See attached Forms List)

Dear Commissioner:

We have enclosed copies of the forms referenced in Appendix A for your review and approval. We are submitting a policy face page and certificate face page with the policy series, P-FACE(2009-12). We are submitting new applications, to reflect our new underwriting standards. We have new rate guarantee language, and therefore we are submitting forms reflecting that language under the forms schedule, as well as corresponding rates. All other forms remain unchanged from our previously approved 2009 filing, P-FACE(2009), et al. In Appendix B, we have included a list of previously approved forms which will be used with the forms listed in Appendix A.

### **Form Description**

We have based this policy series and accompanying previously approved forms on the NAIC 2006 Long-Term Care Model Act and Regulation requirements. These forms: provide for care and treatment in a nursing home, custodial care facility or in an individual's home; are intended to be tax-qualified under HIPAA; and will be used with our group insurance clients. Specifically these forms will be used with employer groups; professional associations; and trusts (not discretionary trusts, but, for example, union groups covered through a trust.)

By way of reminder, note that our policies and certificates are made up of three kinds of forms. The forms named with an initial P- are forms to be issued to the Policyholder only; the forms beginning with D- (for Dual) are forms that will be used in both the policy and in the certificate issued to individual insureds; and forms beginning with C- are forms used only in the certificate distributed to individual insureds.

Please note, we have upgraded our policy 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 printers used. This upgrade does not affect the text content of any form nor produce an unacceptable or dissimilar print. In addition, approved forms may be viewed/printed via website technology. Please see Appendix C for a description of variability.

## Additional Information

This submission is being submitted simultaneously in all 50 states and the District of Columbia. Our company is domiciled in Boston, Massachusetts. We are confident that the group long-term care submission complies with all applicable requirements in your state.

The following items are included in this submission:

- Submission letter
- Above referenced forms
- Actuarial Memorandum and premium rates
- Filing Fee
- All required certifications.

Thank you for your time and consideration in this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Noah Rice". The signature is fluid and cursive, with the first name "Noah" and last name "Rice" clearly distinguishable.

Noah Rice  
Senior Consultant  
LTC Contracts and Legislative Services

**Appendix A – John Hancock’s 2012 Group LTC Portfolio Forms List**

<b>Policy Forms (all beginning P-)</b>	
Policy Shell Face Page	P-FACE(2009-12)
Master Schedule	P-MS (2009-12)
Premiums	P-PREM(2009-12)
<b>Dual Forms for Policy and Certificate (All beginning D-)</b>	
Premiums	D-PREM(2009-12)
<b>Certificate forms (all beginning C-)</b>	
Certificate Face Page	C-FACE(2009-12)
Schedule of Benefits	C-SOB(2009-12)
<b>Applications</b>	
Individual Insured Application	GLTC-APP-STD(2009-12)
Individual Insured Simplified Application	GLTC-APP-STREAM(2009-12)

**Appendix B – Previously approved forms**

<b>Policy Forms (all beginning P-)</b>	
Table of Contents	P-TOC(2009)
Miscellaneous Provisions	P-MISC(2009)
<b>Dual Forms for Policy and Certificate (All beginning D-)</b>	
Table of Contents for Exhibit/booklet portion	D-TOC(2009)
Definitions	D-DEF(2009)
General Provisions	D-GEN(2009)
Group Long-Term Care Insurance	D-LTC(2009)
Limitations and Exclusions	D-EXCL(2009)
Additional Benefits: Inflation Benefits	D-LTC-INF(2009)
Additional Benefits: Nonforfeiture Benefit	D-LTC-NF(2009)
Additional Benefits: Contingent Nonforfeiture Benefit	D-LTC-CNF(2009)
Additional Benefits: Return of Premium Benefit	D-LTC-ROP(2009)
Additional Benefits: Shared Care Benefit	D-LTC-SHC(2009)
Additional Benefits: Monthly Cash Benefit	D-LTC-MCB(2009)
Claims Provisions	D-CLAIM(2009)
Coordination of Benefits	D-COB(2009)
Termination of Coverage	D-TERM(2009)
Miscellaneous Provisions	D-MISC(2009)
<b>Applications</b>	
Policyholder Application	GLTC-PHAPP(2009)
Individual Insured Enrollment Form	GLTC-ENR(2009)
<b>Miscellaneous Forms</b>	
Outline of Coverage	GLTC-DIS(2009)
Long-Term Care Insurance Personal Worksheet	GLTC-SUIT (2009)
Long Term Care Insurance Potential Rate Increase Disclosure Form	GLTC- RID (2009)
Notice of Information Practices	GLTC-INFO(2009)
Policy Amendment Form	P-AMD(2009)
Notice of Change Form	C-NOTICE(2009)

## Appendix C: Variability Guide

### General Guidelines

The following brackets indicate variability. Straight brackets [ ] indicate the surrounded text may come out, if appropriate to the selection made by the Policyholder. Wavy brackets { } indicate the surrounded text/number could be changed.

- The **most restrictive** choice available is shown.
- The final text is driven by the Policyholder's eligibility requirements, administrative preferences and the like. We need to describe conditions as accurately as possible

Ordinary parentheses do not indicate variability.

Sample ranges of schedule numbers are shown on the Master Schedule P-MS(2009), page 3 in the Policy Shell P-FACE(2009-12), et al. Benefits sold will be consistent with the actuarial memorandum included in this submission. In very limited instances these forms may be used to provide facilities-only coverage and any applicable captioning will be changed accordingly.

All page references may change based on final document makeup. Actual page numbers will also vary depending on selections.

In any Group Policy, there are numerous terms to indicate who is covered for what. The term used throughout these documents is "Active or Retired Employee". We seek your permission to change the terms to more accurately describe the group members to be covered, as may be appropriate (e.g. members of a professional or trade association, union group, etc.) We hereby certify that we will not issue contracts covering groups that are not allowed under your statutes. If filing is required for certain groups within your jurisdiction, we will file as appropriate.