

State: Arkansas **Filing Company:** John Hancock Life Insurance Company (USA)
TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII Benefit Builder/MGS111 Application - CCIII Benefit Builder

Filing at a Glance

Company: John Hancock Life Insurance Company (USA)
Product Name: Long-Term Care Insurance
State: Arkansas
TOI: LTC03I Individual Long Term Care
Sub-TOI: LTC03I.001 Qualified
Filing Type: Form
Date Submitted: 08/14/2012
SERFF Tr Num: MULF-128639196
SERFF Status: Closed-Approved
State Tr Num:
State Status: Approved-Closed
Co Tr Num: MGS1 APPLICATION - CCIII BENEFIT BUILDER

Implementation: On Approval
Date Requested:
Author(s): Michelle Fluet, Carol Folsom, Pat Hamlett, Joanne Witham
Reviewer(s): Donna Lambert (primary)
Disposition Date: 08/15/2012
Disposition Status: Approved
Implementation Date:

State Filing Description:

State: Arkansas Filing Company: John Hancock Life Insurance Company (USA)
TOI/Sub-TOI: LTC031 Individual Long Term Care/LTC031.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII Benefit Builder/MGS11 Application - CCIII Benefit Builder

General Information

Project Name: MGS1 Application - CCIII Benefit Builder Status of Filing in Domicile: Pending
Project Number: MGS11 Application - CCIII Benefit Builder Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Our domicile state of Michigan is a member of the Interstate Insurance Compact Product Regulation Commission (IIPRC). This form has been submitted for review to the IIPRC.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 08/15/2012
State Status Changed: 08/15/2012
Deemer Date: Created By: Michelle Fluet
Submitted By: Michelle Fluet Corresponding Filing Tracking Number:

Filing Description:
Re: John Hancock Life Insurance Company (U.S.A.)
Company NAIC # 65838; FEIN #: 01-0233346
Individual Long-Term Care Insurance Submission
Application Form LTC-MGS112 AR

Dear Commissioner:

We have enclosed the above referenced form for your review and approval. A description of this form is found below. This form is a new application form to be used with Custom Care III featuring Benefit Builder individual long-term care insurance policy form LTC-11 AR which was approved by your Department on February 23, 2011 under SERFF Tracking Number MULF-126977796, and recent changes which were approved on June 27, 2012 under SERFF Tracking Number MULF-128202460.

This application form LTC-MGS112 AR is for use with our Sponsored Group Discount program for employers and associations.

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

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

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

Thank you for your time and consideration in this matter.

Sincerely,
Michelle Fluet

State: Arkansas **Filing Company:** John Hancock Life Insurance Company (USA)
TOI/Sub-TOI: LTC031 Individual Long Term Care/LTC031.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII Benefit Builder/MGS111 Application - CCIII Benefit Builder

Company and Contact

Filing Contact Information

Michelle Fluet, Senior Contract Consultant mfluet@jhancock.com
 200 Berkeley Street 617-572-0101 [Phone]
 B6-06 617-572-0399 [FAX]
 Boston, MA 02117

Filing Company Information

John Hancock Life Insurance Company (USA)	CoCode: 65838	State of Domicile: Michigan
200 Berkeley Street	Group Code: 904	Company Type:
Boston, MA 02176	Group Name:	State ID Number:
(617) 572-6000 ext. [Phone]	FEIN Number: 01-0233346	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: 1 form X \$50 = \$50.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
John Hancock Life Insurance Company (USA)	\$50.00	08/14/2012	61670005

SERFF Tracking #:

MULF-128639196

State Tracking #:

Company Tracking #:

MGSI APPLICATION - CCIII BENEFIT
BUILDER

State: Arkansas

Filing Company:

John Hancock Life Insurance Company (USA)

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name: Long-Term Care Insurance

Project Name/Number: MGSI Application - CCIII Benefit Builder/MGSI11 Application - CCIII Benefit Builder

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	08/15/2012	08/15/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	08/15/2012	08/15/2012

Response Letters

Responded By	Created On	Date Submitted
Michelle Fluet	08/15/2012	08/15/2012

SERFF Tracking #:

MULF-128639196

State Tracking #:**Company Tracking #:**MGS1 APPLICATION - CCIII BENEFIT
BUILDER**State:**

Arkansas

Filing Company:

John Hancock Life Insurance Company (USA)

TOI/Sub-TOI:

LTC031 Individual Long Term Care/LTC031.001 Qualified

Product Name:

Long-Term Care Insurance

Project Name/Number:

MGS1 Application - CCIII Benefit Builder/MGS111 Application - CCIII Benefit Builder

Disposition

Disposition Date: 08/15/2012

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	No
Supporting Document	Cover Letter	Approved	No
Supporting Document	Statement of Variability	Approved	No
Form (revised)	Individual Long Term Care Application	Approved	No
Form	Individual Long Term Care Application	Replaced	No

State: Arkansas **Filing Company:** John Hancock Life Insurance Company (USA)
TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII Benefit Builder/MGS111 Application - CCIII Benefit Builder

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 08/15/2012
Submitted Date 08/15/2012
Respond By Date 09/17/2012

Dear Michelle Fluet,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

*- Individual Long Term Care Application, LTC-MGS112 AR (Form)
Comments: Please add confinement "in prison" to the fraud warning.*

Conclusion:

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*

State: Arkansas **Filing Company:** John Hancock Life Insurance Company (USA)
TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified
Product Name: Long-Term Care Insurance
Project Name/Number: MGS1 Application - CCIII Benefit Builder/MGS11 Application - CCIII Benefit Builder

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/15/2012
Submitted Date	08/15/2012

Dear Donna Lambert,

Introduction:

Thank you for your letter.

Response 1

Comments:

We have added confinement "in prison" to the fraud warning.

Related Objection 1

Applies To:

- Individual Long Term Care Application, LTC-MGS112 AR (Form)

Comments: Please add confinement "in prison" to the fraud warning.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

MULF-128639196

State Tracking #:

Company Tracking #:

MGSI APPLICATION - CCIII BENEFIT
BUILDER

State: Arkansas

Filing Company:

John Hancock Life Insurance Company (USA)

TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name: Long-Term Care Insurance

Project Name/Number: MGSI Application - CCIII Benefit Builder/MGSI11 Application - CCIII Benefit Builder

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	LTC-MGSI12 AR	AEF	Individual Long Term Care Application	Initial		LTC-MGSI12 AR .pdf	Date Submitted: 08/15/2012 By: Michelle Fluet

Previous Version

1	LTC-MGSI12 AR	AEF	Individual Long Term Care Application	Initial		LTC-MGSI12 AR .pdf	Date Submitted: 08/15/2012 By: Michelle Fluet
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No Rate/Rule Schedule items changed.

Conclusion:

Should you have any additional questions or concerns, please do not hesitate to contact us.

Sincerely,

Michelle Fluet

SERFF Tracking #:

MULF-128639196

State Tracking #:

Company Tracking #:

MGS1 APPLICATION - CCIII BENEFIT
BUILDER

State:

Arkansas

Filing Company:

John Hancock Life Insurance Company (USA)

TOI/Sub-TOI:

LTC031 Individual Long Term Care/LTC031.001 Qualified

Product Name:

Long-Term Care Insurance

Project Name/Number:

MGS1 Application - CCIII Benefit Builder/MGS111 Application - CCIII Benefit Builder

Form Schedule

Lead Form Number: LTC-MGS112 AR

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/Action Specific Data	Readability Score	Attachments
1	Approved 08/15/2012	LTC-MGS112 AR	AEF	Individual Long Term Care Application	Initial:		LTC-MGS112 AR .pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

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



Control #

Control #

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

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

BUSINESS INFORMATION

Sponsoring Employer Name:

Street Address of Employer:

City:

State:

Zip Code:

[For Agent Use Only:

Applicant A

Applicant B

Underwriting Program:

Underwriting Program:

Simplified Full

Simplified Full

MGSI or Sponsored Group #:

MGSI or Sponsored Group #:]

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

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

[1 John Hancock Place, Boston, MA 02217]



PART 1 ABOUT YOU

APPLICANT A

1a. Name

Last Name _____

First Name _____ M.I. _____

1b. Street Address

Number Street, Apt. # _____

City, State, Zip _____

1c. Contact Information

Telephone # _____

Best Time To Call _____ AM _____ PM

Email Address _____

1d. Alternate Payor Name (if different than applicant)

Name _____

Number Street, Apt. # _____

City, State, Zip _____

1e. Place and Date of Birth

Place _____

DOB (mm/dd/yyyy) _____

1g. Sex

Male Female

1h. Height _____' _____" **Weight** _____ lbs

1ig. Social Security Number

_____-_____-_____

APPLICANT B

1a. Name

Last Name _____

First Name _____ M.I. _____

1b. Street Address Same as Applicant A

Number Street, Apt. # _____

City, State, Zip _____

1c. Contact Information

Telephone # _____

Best Time To Call _____ AM _____ PM

Email Address _____

1d. Alternate Payor Name (if different than applicant)

Name _____

Number Street, Apt. # _____

City, State, Zip _____

1e. Place and Date of Birth

Place _____

DOB (mm/dd/yyyy) _____

1g. Sex

Male Female

1h. Height _____' _____" **Weight** _____ lbs

1i. Social Security Number

_____-_____-_____

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

PART 2 EMPLOYMENT INFORMATION

2a. Are you currently actively at work?

Yes No

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

2a. Are you currently actively at work?

Yes No

2b. Relationship to Employee

2b. Relationship to Employee

2c. Which applies to you?

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

2c. Which applies to you?

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

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

(mm/dd/yyyy) _____

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

(mm/dd/yyyy) _____

PART 3 DISCOUNTS & OTHER NEEDED INFORMATION

3a. Beneficiary Designation

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

Name & Address (for Applicant A) _____

Name & Address (for Applicant B) _____

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

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

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

SECTION A – Should You Proceed with This Application?

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

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

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

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

SECTION B – Medical History

		Applicant A		Applicant B	
		YES	NO	YES	NO
4f.	In the last 18 months, have you been treated, examined or advised by a member of the medical profession? (If yes, complete the information below).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant A

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

Applicant B

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

		Applicant A		Applicant B	
		YES	NO	YES	NO
4g.	Do you have a Primary Care Physician? (If yes, complete the information below).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A		Applicant B			
Date Last Seen	_____	Date Last Seen	_____		
Physician Name	_____	Physician Name	_____		
Street Address	_____	Street Address	_____		
City, State, Zip	_____	City, State, Zip	_____		
Telephone #	_____	Telephone #	_____		
4h.	Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4i.	Within the last 5 years, have you received medical advice, diagnosis or treatment from a member of the medical profession for any of the following conditions? <i>Please indicate each that applies and provide details in the Medical History Details.</i>				
1.	Circulatory Disorders: <input type="checkbox"/> Amaurosis Fugax <input type="checkbox"/> Aneurysm <input type="checkbox"/> Blood Clots <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Carotid Artery Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Embolisms <input type="checkbox"/> Heart Arrhythmias <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Endocrine and Pituitary Disorders: <input type="checkbox"/> Diabetes <input type="checkbox"/> Addison's Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Cushing's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Cancers: <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Tumors <input type="checkbox"/> Melanoma <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Sarcomas <input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Genitourinary Disorders: <input type="checkbox"/> Renal Insufficiency <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Incontinence <input type="checkbox"/> Prostate Disorders <input type="checkbox"/> Bladder Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Gastrointestinal Disorders: <input type="checkbox"/> Hepatitis <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Liver Disorders <input type="checkbox"/> Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Neurological Disorders: <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis <input type="checkbox"/> Anxiety <input type="checkbox"/> Cerebral Atrophy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Memory Loss <input type="checkbox"/> Mental Illness <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Possible Multiple Sclerosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Neurological conditions affecting the brain or spinal cord <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Polyneuropathy <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Seizures <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Syncope <input type="checkbox"/> Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Blood Disorders: <input type="checkbox"/> Anemia, <input type="checkbox"/> Leukopenia <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Musculoskeletal Disorders: <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fractures <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Lupus <input type="checkbox"/> Polymyalgia Rheumatica <input type="checkbox"/> Osteopenia <input type="checkbox"/> Paralysis <input type="checkbox"/> Crest <input type="checkbox"/> Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Respiratory Disorders: <input type="checkbox"/> Emphysema, <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Asbestosis <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

		Applicant A		Applicant B	
		YES	NO	YES	NO
4i. (cont)	Within the last 5 years, have you received medical advice, diagnosis or treatment from a member of the medical profession for any of the following conditions?				
	10. Eye & Ear Disorders: <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Labrynthitis <input type="checkbox"/> Meniere's/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11. Substance Abuse: <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug dependency <input type="checkbox"/> Illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4j.	Within the last 5 years have you been hospitalized or been treated by a member of the medical profession for any reason not previously stated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4k.	Within the last 5 years, has any surgery or test(s) been recommended and not performed or any medication been prescribed and not taken?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4l.	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, list medical reason: Applicant A: _____ Applicant B: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4m.	Have you applied for or are you receiving any disability benefits? Applicant A: Type _____ Percentage _____ Medical Reason _____ Applicant B: Type _____ Percentage _____ Medical Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4n.	Have any of your family members (mother, father or siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions? (Please indicate all that apply) <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (Lou Gehrig's) <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[LIFESTYLE (PLEASE COMPLETE THIS SECTION IF YOU ARE 64 OR YOUNGER.)					
4o.	Are you currently employed? If yes, what is your occupation? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4p.	In the past 10 years have you done or in the future, do you intend within the next 2 years to do any of the following activities? Skin/scuba Diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? Frequency? Applicant A: Activity Type _____ Frequency Per Year _____ Applicant B: Activity Type _____ Frequency Per Year _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4q.	In the past 5 years, have you been convicted of two or more felony motor vehicle moving violations or had a driver's license suspended or revoked? If yes, license # and state. Applicant A _____ Applicant B _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

MEDICAL HISTORY DETAILS

If you answered YES to any of questions 43h-43l, provide full details below. Attach a separate sheet if you need additional space.

Applicant A

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

Applicant B

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

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

MEDICAL HISTORY DETAILS

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

Applicant A

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

Applicant B

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

4q. MEDICATIONS

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

Applicant A	Dosage	Frequency	Reason Prescribed	Physician Name

Applicant B

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

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

PART 5 COVERAGE SELECTION - [Product Name]

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

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

PART 6 PREMIUM PAYMENT & ADMINISTRATION

	Applicant A	Applicant B
6a. Who will be paying the premium?	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.
6b. Premium Payment Type	<input checked="" type="checkbox"/> Standard Pay	<input checked="" type="checkbox"/> Standard Pay

[6c. Payment Method

Please select one of the following for each applicant.

1. Select a mode of payment	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	<input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly
2. Payment Type	<input type="checkbox"/> Direct Bill* <input type="checkbox"/> Bank Draft (Electronic Fund Transfer)	<input type="checkbox"/> Direct Bill* <input type="checkbox"/> Bank Draft (Electronic Fund Transfer)

**Monthly mode of payment not available.*

Please include a voided check and complete form ADP for Bank Draft

An Advance Payment is required.

I have enclosed my advance payment in the amount of \$_____ (minimum of one month's modal premium)

Please make checks payable to John Hancock Life Insurance Company (U.S.A.). Do not make check payable to the agent or leave the payee blank. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.

3. Is this a List Bill?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Please check if this is a new List Bill.		

Group Number: _____

Group Name: _____]

PART 7 INSURANCE HISTORY

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

PART 8 PROTECTION AGAINST UNINTENDED LAPSE

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

Applicant A

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

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

Applicant B

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

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

PART 9 SPECIAL REQUESTS

PART 10 DECLARATION AND AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

1. I have received the Outline of Coverage, Notice of Insurance Information Practices, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, the Potential Rate Increase Disclosure, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacing coverage) and the Guide to Health Insurance for People with Medicare (if eligible for Medicare).
2. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
3. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
4. John Hancock Life Insurance Company (U.S.A.) ("John Hancock") may require an attending physician statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
5. I have read and reviewed the application. My statements and answers on this application are true, complete and correctly recorded to the best of my knowledge. They are representations and not warranties, and will be part of and form the basis of my policy being issued.
6. [Under the Benefit Builder option (if included in my policy), I understand that portfolio rates of return are not guaranteed and there will be little or no benefit increase in the early years of my policy.]

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

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

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

Applicant A

Signature

X _____

Applicant B

Signature

X _____

Signed at (City & State)

Date

Signed at (City & State)

Date

PART 11 PRODUCER/AGENT'S STATEMENT

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

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

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

	Applicant A	Applicant B
Please indicate the Underwriting Risk Classification quoted:	<input type="checkbox"/> Preferred	<input type="checkbox"/> Preferred
<i>Note: LTC Underwriting will determine the appropriate risk class regardless of that quoted to the applicant. We will communicate any change.</i>	<input type="checkbox"/> Select	<input type="checkbox"/> Select
	<input type="checkbox"/> Class 1	<input type="checkbox"/> Class 1
	<input type="checkbox"/> Class 2	<input type="checkbox"/> Class 2

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

Signature of Licensed Producer: _____

Producer Name (Please print): _____ Date: _____

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

SERFF Tracking #:

MULF-128639196

State Tracking #:**Company Tracking #:**MGSi APPLICATION - CCIII BENEFIT
BUILDER**State:**

Arkansas

Filing Company:

John Hancock Life Insurance Company (USA)

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

Long-Term Care Insurance

Project Name/Number:

MGSi Application - CCIII Benefit Builder/MGSi11 Application - CCIII Benefit Builder

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	08/15/2012
Comments:			
Attachment(s):			
CERTIFICATION OF READABILITY.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	08/15/2012
Comments:	The application has been attached to the "Form Schedule" tab.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	08/15/2012
Bypass Reason:	Not applicable - no rates being filed.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	08/15/2012
Bypass Reason:	Please see previously approved SERFF Tracking Number MULF-128202460 (approved on June 27, 2012).		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved	08/15/2012
Comments:			
Attachment(s):			
AR MGSi 2012 Cover Letter.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	08/15/2012
Comments:			

SERFF Tracking #:	MULF-128639196	State Tracking #:		Company Tracking #:	MGSI APPLICATION - CCIII BENEFIT BUILDER
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State:	Arkansas	Filing Company:	John Hancock Life Insurance Company (USA)
TOI/Sub-TOI:	LTC03I Individual Long Term Care/LTC03I.001 Qualified		
Product Name:	Long-Term Care Insurance		
Project Name/Number:	MGSI Application - CCIII Benefit Builder/MGSI11 Application - CCIII Benefit Builder		

Attachment(s):

AR MGSI Variability Statement.pdf

**CERTIFICATION OF READABILITY
State of Arkansas**

Policy Form	LTC-11 AR
Application	
MGSI Application	LTC-MSGI12 AR

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

8/14/12
Date

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


Signature of officer of the Issuer

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

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



Michelle Fluet
Contract Consultant
LTC Contracts and Legislative Services

August 14, 2012

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

Re: **John Hancock Life Insurance Company (U.S.A.)**
Company NAIC # 65838; FEIN #: 01-0233346
Individual Long-Term Care Insurance Submission
Application Form LTC-MGSI12 AR

Dear Commissioner:

We have enclosed the above referenced form for your review and approval. A description of this form is found below. This form is a new application form to be used with Custom Care III featuring Benefit Builder individual long-term care insurance policy form LTC-11 AR which was approved by your Department on February 23, 2011 under SERFF Tracking Number MULF-126977796, and recent changes which were approved on June 27, 2012 under SERFF Tracking Number MULF-128202460.

This application form LTC-MGSI12 AR is for use with our Sponsored Group Discount program for employers and associations.

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

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

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

Thank you for your time and consideration in this matter.

Sincerely,

Michelle Fluet

Statement of Variability – Application

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

Form LTC-MGSI12 AR

Address may change if we move our administration offices.

1. Page 1, For Agent Use Only section may be removed entirely if not applicable to sales distribution channel.
2. Page 6, Questions 4a-4q
 - Questions may be removed entirely, if applicants are over age 64.
3. Page 9 – Part 5
 - Modified Standard Issue Program available benefits may vary based sales distribution channel, the benefits offered will at no time be less than the minimums standard.
 - Question 5a Benefit Amount
 - Either the Daily or Monthly benefit offer may be removed. At no time will the benefit offered be less than the minimum standard.
 - Question 5b Benefit Period
 - Benefit period may vary based on sales distribution channel, the benefit period offered will at no time be less than the minimum standard.
 - Question 5c Elimination Period
 - Some Elimination Periods may be removed based on the sales distribution channel.
 - Question 5d – Inflation Options
 - Inflation Option availability may vary based on sales distribution channel (variation by those displayed shown not any other options)
 - 5% Compound will always be offered.
 - Question 5e – Optional Benefits
 1. Optional benefit availability may vary based on sales distribution channel. (variation by those displayed shown not any other options).
 2. Nonforfeiture will always be offered.
4. Page 10 – Part 6
 - Question 6c
 1. Payment Method availability may vary based on sales distribution channel. (variation by those displayed shown not any other options)
5. Page 11 – Premium Agreement and Authorization
 - Statement #4
 1. Bracketed information will be removed for non-payroll deductions, list bill or employer pay plans that no advance payment is required.
6. Page 12 – Part 9 Declaration and Authorizations
 - General Agreement & Acknowledgment
 - Item 6. Statement may be eliminated based upon inflation option availability.

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

Superseded Schedule Items

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

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/14/2012	Form	Individual Long Term Care Application	08/15/2012	LTC-MGSI12 AR .pdf (Superseded)

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

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

[1 John Hancock Place, Boston, MA 02217]



Control #

Control #

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

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

BUSINESS INFORMATION

Sponsoring Employer Name:

Street Address of Employer:

City:

State:

Zip Code:

[For Agent Use Only:

Applicant A

Applicant B

Underwriting Program:

Underwriting Program:

Simplified Full

Simplified Full

MGSI or Sponsored Group #:

MGSI or Sponsored Group #:]

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

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

[1 John Hancock Place, Boston, MA 02217]



PART 1 ABOUT YOU

APPLICANT A

1a. Name

Last Name _____

First Name _____ M.I. _____

1b. Street Address

Number Street, Apt. # _____

City, State, Zip _____

1c. Contact Information

Telephone # _____

Best Time To Call _____ AM _____ PM

Email Address _____

1d. Alternate Payor Name (if different than applicant)

Name _____

Number Street, Apt. # _____

City, State, Zip _____

1e. Place and Date of Birth

Place _____

DOB (mm/dd/yyyy) _____

1g. Sex

Male Female

1h. Height _____' _____" **Weight** _____ lbs

1i. Social Security Number

_____-_____-_____

APPLICANT B

1a. Name

Last Name _____

First Name _____ M.I. _____

1b. Street Address Same as Applicant A

Number Street, Apt. # _____

City, State, Zip _____

1c. Contact Information

Telephone # _____

Best Time To Call _____ AM _____ PM

Email Address _____

1d. Alternate Payor Name (if different than applicant)

Name _____

Number Street, Apt. # _____

City, State, Zip _____

1e. Place and Date of Birth

Place _____

DOB (mm/dd/yyyy) _____

1g. Sex

Male Female

1h. Height _____' _____" **Weight** _____ lbs

1i. Social Security Number

_____-_____-_____

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

PART 2 EMPLOYMENT INFORMATION

2a. Are you currently actively at work?

Yes No

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

2a. Are you currently actively at work?

Yes No

2b. Relationship to Employee

2b. Relationship to Employee

2c. Which applies to you?

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

2c. Which applies to you?

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

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

(mm/dd/yyyy) _____

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

(mm/dd/yyyy) _____

PART 3 DISCOUNTS & OTHER NEEDED INFORMATION

3a. Beneficiary Designation

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

Name & Address (for Applicant A) _____

Name & Address (for Applicant B) _____

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

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

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

SECTION A – Should You Proceed with This Application?

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

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

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

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

SECTION B – Medical History

		Applicant A		Applicant B	
		YES	NO	YES	NO
4f.	In the last 18 months, have you been treated, examined or advised by a member of the medical profession? (If yes, complete the information below).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant A

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

Applicant B

Date Last Seen _____

Physician Name _____

Street Address _____

City, State, Zip _____

Telephone # _____

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

		Applicant A		Applicant B	
		YES	NO	YES	NO
4g.	Do you have a Primary Care Physician? (If yes, complete the information below).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applicant A		Applicant B			
Date Last Seen	_____	Date Last Seen	_____		
Physician Name	_____	Physician Name	_____		
Street Address	_____	Street Address	_____		
City, State, Zip	_____	City, State, Zip	_____		
Telephone #	_____	Telephone #	_____		
4h.	Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4i.	Within the last 5 years, have you received medical advice, diagnosis or treatment from a member of the medical profession for any of the following conditions? <i>Please indicate each that applies and provide details in the Medical History Details.</i>				
1.	Circulatory Disorders: <input type="checkbox"/> Amaurosis Fugax <input type="checkbox"/> Aneurysm <input type="checkbox"/> Blood Clots <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Carotid Artery Disease <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Embolisms <input type="checkbox"/> Heart Arrhythmias <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Transient Ischemic Attack <input type="checkbox"/> Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Endocrine and Pituitary Disorders: <input type="checkbox"/> Diabetes <input type="checkbox"/> Addison's Disease <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Cushing's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Cancers: <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Tumors <input type="checkbox"/> Melanoma <input type="checkbox"/> Squamous Cell <input type="checkbox"/> Sarcomas <input type="checkbox"/> Multiple Myeloma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Genitourinary Disorders: <input type="checkbox"/> Renal Insufficiency <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Incontinence <input type="checkbox"/> Prostate Disorders <input type="checkbox"/> Bladder Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Gastrointestinal Disorders: <input type="checkbox"/> Hepatitis <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Liver Disorders <input type="checkbox"/> Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Neurological Disorders: <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis <input type="checkbox"/> Anxiety <input type="checkbox"/> Cerebral Atrophy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Dementia <input type="checkbox"/> Depression <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Memory Loss <input type="checkbox"/> Mental Illness <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Possible Multiple Sclerosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Neurological conditions affecting the brain or spinal cord <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Polyneuropathy <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Seizures <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Syncope <input type="checkbox"/> Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Blood Disorders: <input type="checkbox"/> Anemia, <input type="checkbox"/> Leukopenia <input type="checkbox"/> Polycythemia Vera <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Hemochromatosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Musculoskeletal Disorders: <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fractures <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Degenerative Joint Disease <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> Lupus <input type="checkbox"/> Polymyalgia Rheumatica <input type="checkbox"/> Osteopenia <input type="checkbox"/> Paralysis <input type="checkbox"/> Crest <input type="checkbox"/> Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Respiratory Disorders: <input type="checkbox"/> Emphysema, <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Asbestosis <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

		Applicant A		Applicant B	
		YES	NO	YES	NO
4i. (cont)	Within the last 5 years, have you received medical advice, diagnosis or treatment from a member of the medical profession for any of the following conditions?				
	10. Eye & Ear Disorders: <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Labrynthitis <input type="checkbox"/> Meniere's/Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11. Substance Abuse: <input type="checkbox"/> Alcohol Use <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug dependency <input type="checkbox"/> Illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4j.	Within the last 5 years have you been hospitalized or been treated by a member of the medical profession for any reason not previously stated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4k.	Within the last 5 years, has any surgery or test(s) been recommended and not performed or any medication been prescribed and not taken?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4l.	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, list medical reason: Applicant A: _____ Applicant B: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4m.	Have you applied for or are you receiving any disability benefits? Applicant A: Type _____ Percentage _____ Medical Reason _____ Applicant B: Type _____ Percentage _____ Medical Reason _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4n.	Have any of your family members (mother, father or siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions? (Please indicate all that apply) <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Amyotrophic Lateral Sclerosis (Lou Gehrig's) <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
[LIFESTYLE (PLEASE COMPLETE THIS SECTION IF YOU ARE 64 OR YOUNGER.)					
4o.	Are you currently employed? If yes, what is your occupation? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4p.	In the past 10 years have you done or in the future, do you intend within the next 2 years to do any of the following activities? Skin/scuba Diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? Frequency? Applicant A: Activity Type _____ Frequency Per Year _____ Applicant B: Activity Type _____ Frequency Per Year _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4q.	In the past 5 years, have you been convicted of two or more felony motor vehicle moving violations or had a driver's license suspended or revoked? If yes, license # and state. Applicant A _____ Applicant B _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

MEDICAL HISTORY DETAILS

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

Applicant A

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

Applicant B

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

PART 4 INSURABILITY QUESTIONS (Underwriting Questions)

SECTION B – Medical History (continued)

MEDICAL HISTORY DETAILS

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

Applicant A

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

Applicant B

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

4q. MEDICATIONS

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

Applicant A	Dosage	Frequency	Reason Prescribed	Physician Name

Applicant B

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name

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

PART 5 COVERAGE SELECTION - [Product Name]

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

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

PART 6 PREMIUM PAYMENT & ADMINISTRATION

	Applicant A	Applicant B
6a. Who will be paying the premium?	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.	<input type="checkbox"/> 100% Employer Paid <input type="checkbox"/> Partial Employer Paid <input type="checkbox"/> Insured Paid.
6b. Premium Payment Type	<input checked="" type="checkbox"/> Standard Pay	<input checked="" type="checkbox"/> Standard Pay

[6c. Payment Method

Please select one of the following for each applicant.

1. Select a mode of payment

- | | |
|--|--|
| <input type="checkbox"/> Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Semi-Annually |
| <input type="checkbox"/> Quarterly | <input type="checkbox"/> Quarterly |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Monthly |

2. Payment Type

**Monthly mode of payment not available.*

- | | |
|---|---|
| <input type="checkbox"/> Direct Bill* | <input type="checkbox"/> Direct Bill* |
| <input type="checkbox"/> Bank Draft
(Electronic Fund Transfer) | <input type="checkbox"/> Bank Draft
(Electronic Fund Transfer) |

Please include a voided check and complete form ADP for Bank Draft

An Advance Payment is required.

I have enclosed my advance payment in the amount of \$_____ (minimum of one month's modal premium)

Please make checks payable to John Hancock Life Insurance Company (U.S.A.). Do not make check payable to the agent or leave the payee blank. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.

3. Is this a List Bill?

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|

Please check if this is a new List Bill.

Group Number:		
Group Name:		

PART 7 INSURANCE HISTORY

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

PART 8 PROTECTION AGAINST UNINTENDED LAPSE

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

Applicant A

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

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

Applicant B

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

Name of Person _____

Number Street, Apt. # _____

City, State, Zip Code _____

PART 9 SPECIAL REQUESTS

PART 10 DECLARATION AND AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

1. I have received the Outline of Coverage, Notice of Insurance Information Practices, Long-Term Care Insurance Personal Worksheet, Things You Should Know Before You Buy Long-Term Care Insurance, the Potential Rate Increase Disclosure, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacing coverage) and the Guide to Health Insurance for People with Medicare (if eligible for Medicare).
2. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
3. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
4. John Hancock Life Insurance Company (U.S.A.) ("John Hancock") may require an attending physician statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
5. I have read and reviewed the application. My statements and answers on this application are true, complete and correctly recorded to the best of my knowledge. They are representations and not warranties, and will be part of and form the basis of my policy being issued.
6. [Under the Benefit Builder option (if included in my policy), I understand that portfolio rates of return are not guaranteed and there will be little or no benefit increase in the early years of my policy.]

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

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

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

Applicant A

Signature

X _____

Applicant B

Signature

X _____

Signed at (City & State)

Date

Signed at (City & State)

Date

PART 11 PRODUCER/AGENT'S STATEMENT

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

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

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

	Applicant A	Applicant B
Please indicate the Underwriting Risk Classification quoted:	<input type="checkbox"/> Preferred	<input type="checkbox"/> Preferred
<i>Note: LTC Underwriting will determine the appropriate risk class regardless of that quoted to the applicant. We will communicate any change.</i>	<input type="checkbox"/> Select	<input type="checkbox"/> Select
	<input type="checkbox"/> Class 1	<input type="checkbox"/> Class 1
	<input type="checkbox"/> Class 2	<input type="checkbox"/> Class 2

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

Signature of Licensed Producer: _____

Producer Name (Please print): _____ Date: _____

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