
This kit is for all John Hancock products (including LifeCare Benefit Rider), excluding John Hancock New York

Applications for John Hancock New York, Term Conversion and Policy Change may be obtained from www.jhsalesnet.com or any other of our producer web sites. Requests for hardcopy forms and COLI applications may be made through any John Hancock regional office.

1. Do You Have the Correct Form?

The application form must be taken in the state where solicitation took place. In most cases, the state of issue will be where the Owner resides and solicitation took place. The following governing principals must always be followed when determining state of issue:

- The application form must be signed in the state where solicitation took place.
- The agent must be licensed in the state where solicitation took place.
- The product must be approved in the state where solicitation took place.
- Policy delivery must be or must be deemed to be in the state where solicitation took place.
- There must be a relationship between the owner and the state of solicitation.

For more details, see 'State selection help' on the New Business Electronic Forms on www.jhsalesnet.com.

2. Buyer's Guide

A Buyer's Guide must be given to the Owner at time of the application. A link to the correct Buyer's Guide for the state of solicitation is available on the 'View My Forms' Page when searching for a state specific kit using 'New Business Online Forms'.

3. Employer/Corporate Owned Policies

- If the policy being applied for is employer/corporate owned with an employer/corporate beneficiary, Section 101(j) of the Internal Revenue Code (IRC) may apply.
- Please consult a tax professional prior to submission of the application to ensure compliance and understanding of the notice and consent requirements of section 101(j).

4. Military Personnel Policies

Military Personnel policies are policies where an active duty service member is the Proposed Life Insured or the Owner of a policy on the life of their spouse or children. For these applications, Form **NB5109US** must be submitted. This form is available in the Non Underwriting Forms section of 'View My Forms'.

5. Special Riders/Benefits Instructions

The following benefits/riders have specific instructions that must be followed if the particular benefit/rider is requested

- **Children's Insurance Rider or Applicant Waiver** – Complete Form **NB5020**. This form is part of the application kit if this option is selected.
- **LifeCare Benefit Rider** – Follow the Life Care Benefit kit instructions (following page) to ensure the correct Outline of Coverage is given to the Proposed Life Insured.
- **Living Care Benefit (John Hancock legacy products)** – Provide the Proposed Life Insured with the **Disclosure Statement, DISC-1-LCB**. The Proposed Life Insured must sign the statement as the Applicant.
- **Accelerated Death Benefit** (for terminal illness) – Provide the **Owner** with the **Disclosure Statement, NB1237**.

Instructions for LifeCare Benefit Rider

- Complete and submit the **LifeCare Benefit Rider application, NB5018**.
- Provide the Proposed Life Insured with:
 - **Notice of Replacement, NB5019**, if other coverage is being replaced.
 - **Notice of Protected Health Information Privacy Practices, NB5059US**.
 - **Guide to Health Insurance for People with Medicare, LTC1014**, if the Proposed Life Insured is age 65 or older. This guide is available on a link on the 'View My Forms' Page when searching for a kit using 'New Business Online Forms'.
- **Outline of Coverage**.

Do You Have the Correct Outline of Coverage?

The Outline of Coverage form is specific to the type of product requested. The following grid has been designed to help determine which form should be provided.

Universal/Variable Life Insurance	Traditional/Term Life Insurance
05OCLTCU or 07OCLTCU	08WLOCLTCU

Shopper's Guide to Long Term Care Insurance, LTC-1059 can be obtained by accessing the LTC order system via www.jhltc.com with an order number of LTC-1059 or by contacting the Literature line at 1-800-892-9552.



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

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

Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s) and Owner.

PROPOSED LIFE INSURED(S) LIFE ONE

LIFE TWO (Survivorship)

1. a) Name _____
First Middle Last

b) Date of Birth _____ c) Sex M F
month day year

d) Place of Birth _____
State Country

e) Citizenship U.S. Other _____

f) Social Security Number (SSN),
 if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____
Address - Street No. & Name Apt. No.

_____ City State Zip Code

i) Years at this Address _____

j) Tel. Nos. _____
Home Business

k) If you live at your primary residence less than 6 months per year,
 provide the address for your secondary residence.
 Secondary Residence _____
Address - Street No. & Name Apt. No.

_____ City State Zip Code

l) Years at this Address _____

m) Occupation _____
Name of Employer

2. a) Name _____
First Middle Last

b) Date of Birth _____ c) Sex M F
month day year

d) Place of Birth _____
State Country

e) Citizenship U.S. Other _____

f) Social Security Number (SSN),
 if applicable _____

g) Driver's License No. _____ State _____

h) Primary Residence _____
Address - Street No. & Name Apt. No.

_____ City State Zip Code

i) Years at this Address _____

j) Tel. Nos. _____
Home Business

k) If you live at your primary residence less than 6 months per year,
 provide the address for your secondary residence.
 Secondary Residence _____
Address - Street No. & Name Apt. No.

_____ City State Zip Code

l) Years at this Address _____

m) Occupation _____
Name of Employer

OWNER – Complete only if Owner is other than Proposed Life Insured(s)

If Trust Owner,
complete questions
3. a), d) and e) and
Trust Certification
PS5101.

Trust Agreement
may be required.

Provide all details as
above for other
Owner in Special
Requests on Page 4.

3. a) Name _____

b) Date of Birth _____ c) Relationship to Proposed Life Insured(s) _____
month day year

d) Social Security/Tax ID Number, if applicable _____

e) Address _____
Street No. & Name Apt. No. City State Zip Code

4. Multiple Owners
 Type of ownership Joint with right of survivorship Tenants in common

BENEFICIARY INFORMATION – Subject to change by Owner

List additional
beneficiaries in
Special Requests
on Page 4.

5. a) Name _____ Primary _____ %
First Middle Last Relationship to Proposed Life Insured(s) Percentage

b) Name _____ Primary _____ %
First Middle Last Relationship to Proposed Life Insured(s) Percentage

Secondary _____ %
 Relationship to Proposed Life Insured(s) Percentage

EXISTING AND PENDING INSURANCE

If more space is required attach additional page that has been signed and dated by Owner if necessary.

6. a) Provide information for each policy in force on the Proposed Life Insured(s) with all companies, including any policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity.

Proposed Life Insured	Company	Insurance		Issue Date			To Remain in Force?		Amount Including Riders
		Personal	Business	month	day	year	Yes	No	
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$
<input type="checkbox"/> One <input type="checkbox"/> Two		<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	\$

- b) Have you ever had an application for life insurance declined, postponed, rated substandard or offered with a reduced face amount?

Life One No Yes – give details _____

Life Two No Yes – give details _____

- c) Including this application, total insurance currently applied for with all companies (**not including informal inquiries**).

Provide name of Life Insurance Company and amount applied for.

Life One		Life Two	
Company	Amount Including Riders	Company	Amount Including Riders
	\$		\$
	\$		\$
	\$		\$

- d) Of the total amount applied for in c) above including this application, what is the maximum that you will accept?

Life One	Life Two
\$	\$

JUVENILE INSURANCE

Complete e) & f) if juvenile insurance is applied for.

- e) Are all siblings equally insured? Yes No

- f) Amount of life insurance currently in force or pending on parent(s)/guardian(s)? \$ _____

If none, provide reason. _____

REPLACEMENTS – OWNER

7. Will this insurance replace existing policies or are you considering using funds from existing policies to pay premiums due on the new policy or contract?

Yes No If 'Yes', please complete the **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Standard Form), NB5017**.

FINANCIAL QUESTIONS

Copies of financial statements, estate analyses, contractual agreements may be required.

8. Is there, or are you considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in this application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of this application?

No Yes - If 'Yes', provide details _____

9. Have you been offered any money or other considerations by any person or entity in connection with this application?

No Yes - If 'Yes', provide details _____

- 10.a) What is the source of the premiums for the policy(ies) currently applied for? _____

- b) Will the Owner be receiving funding for the premiums from an individual and/or entity other than the Proposed Life Insured(s) or the Proposed Life Insured's employer?

Yes - If 'Yes', answer question 11 below.

No - If 'No', proceed to question 12.

- 11.a) Will the premiums be financed through a loan?

No - If 'No' describe the funding arrangement _____

Yes - If 'Yes' provide the loan details in question 11 b), c), d), e) and f) below.

- b) What is the annual interest rate? _____ %

- c) In addition to repayment of principal and interest, are there other fees, charges or other consideration to be paid?

No Yes - If 'Yes', provide details _____

FINANCIAL QUESTIONS continued

Copies of financial statements, estate analyses, contractual agreements may be required.

11. d) What is the duration of the loan? _____
 e) Who is the lender? _____
 f) What amount and type of collateral is required to secure the loan? \$ _____
 Amount Type of Collateral
- 12.a) What is the purpose of this insurance? _____
 (e.g. estate conservation, buy-sell, keyperson)
- | | Life One | Life Two |
|---|----------|----------|
| b) Gross annual earned income (salary, commissions, bonuses, etc.) | \$ _____ | \$ _____ |
| c) Gross annual unearned income (dividends, interest, gross real estate income, etc.) | \$ _____ | \$ _____ |
- d) Household net worth (combined) \$ _____
 e) In the last 5 years, has the Proposed Life Insured(s) or any business of which he/she is a partner/owner/executive had any major financial problems (bankruptcy, etc.)? Life One No Yes - give details _____
 Life Two No Yes - give details _____

BUSINESS FINANCIAL QUESTIONS

Complete for ALL Business Insurance.

Copies of financial statements may be required.

- | | Current Year | Previous Year |
|--------------------------------------|--------------|---------------|
| 13.a) Assets | \$ _____ | \$ _____ |
| b) Liabilities | \$ _____ | \$ _____ |
| c) Gross Sales | \$ _____ | \$ _____ |
| d) Net Income | \$ _____ | \$ _____ |
| e) Fair Market Value of the business | \$ _____ | \$ _____ |
- f) How was the amount applied for determined? _____
 g) What percentage of the business is owned by the Proposed Life Insured(s)? _____ %
 h) Are other partners/owners/executives insured or applying for life insurance with any company? No Yes - give details _____

LIFESTYLE QUESTIONS

Please provide details in No. 18 for 'Yes' answers to Lifestyle Questions.

14. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?
 15.a) Have you flown as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes, in the last 2 years?
 If 'Yes', please complete **Aviation Questionnaire NB5009**.
 b) Have you engaged in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountain climbing, or any other hazardous activities in the last 2 years?
 If 'Yes', please complete **Avocation Questionnaire NB5010**.
 16.a) Have you been cited for 2 or more moving violations within the last 2 years?
 b) Have you been cited for driving while intoxicated or while otherwise impaired?
 17. In the last 10 years, have you been convicted of a felony offense?

Life One	Life Two
<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	<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
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

18.	Question No.	Life One	Question No.	Life Two

PRIMARY PHYSICIAN – PROPOSED LIFE INSURED(S)

LIFE ONE

19. Provide name and address of primary physician.

Name _____
 First Middle Last
 Address _____
 Street No. & Name Suite No.
 City State Zip Code

LIFE TWO

20. Provide name and address of primary physician.

Name _____
 First Middle Last
 Address _____
 Street No. & Name Suite No.
 City State Zip Code

INFORMATION REGARDING LAST MEDICAL CONSULTATION

LIFE ONE

- 21.a) Date of last visit to ANY doctor/physician _____
month day year
- b) Reason for visit _____
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed _____
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

LIFE TWO

- 22.a) Date of last visit to ANY doctor/physician _____
month day year
- b) Reason for visit _____
- c) Diagnosis or outcome of visit _____
- d) Treatment/medication prescribed _____
- e) Name of doctor/physician for above (check one)
 Primary doctor/physician
 Other doctor/physician (provide name and address)

First Middle Last

Street No. & Name Suite No.

City State Zip Code

23. Has a **John Hancock Medical Exam NB5033** been completed or will it be completed?
 If 'No', complete question 24 and Medical Examination from Another Insurer section below.
24. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 If 'Yes', give details below.

Life One	Life Two
<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

Life One:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes _____	pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Life Two:				Date Last Used		
Product	Frequency	Current	Past	month	day	year
Cigarettes _____	pack(s)/day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Cigars _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other: _____	x /day	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

MEDICAL EXAMINATION FROM ANOTHER INSURER

Complete this section when submitting a medical examination form of another company in lieu of John Hancock Medical Exam NB5033.

25.

	Name of Proposed Life Insured	Name of Insurance Company	Date of Examination		
			month	day	year
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

- a) To the best of your knowledge and belief, is the information in the examination true and complete as of the date this application is signed? (Note: The examination cannot be older than 180 days prior to the date of this application.)

Life One	Life Two
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

COVERAGE APPLIED FOR

26. Complete the applicable **Coverage Details Form NB5007** (Universal Life), **NB5008** (Variable Life) or **NB5013** (Term & Traditional Life) for details of the policy being applied for, including Supplementary Benefits and other benefit options.

SPECIAL REQUESTS – Attach additional page if more space is required.

TEMPORARY LIFE INSURANCE AGREEMENT APPLICATION

Money may NOT be collected and the **Temporary Life Insurance Receipt and Agreement NB5004** may NOT be issued if:

1. questions 28 and 29 are answered Yes; or
2. the Proposed Life Insured(s) is under age 20 or over age 70; or
3. the amount applied for is more than \$10,000,000 (single life) or \$15,000,000 (survivorship).

27. Is coverage being applied for under the Temporary Life Insurance Agreement? Yes No

If 'Yes', answer questions 28 and 29.

28. Within the last 24 months, has the Proposed Life Insured(s) under this application:

- a) consulted a medical professional, been diagnosed with or been treated for or had treatment recommended by a member of the medical profession for any heart problem, stroke or cancer?
- b) consulted with or scheduled a consultation with a medical professional for any medical concerns?
- c) received a recommendation from a medical professional for any consultation, testing, investigation or surgery that has not yet been completed?
- d) been declined for life insurance?

Life One	Life Two
<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	<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

29. Does the Proposed Life Insured(s) reside outside the United States more than 6 months per year?

PRE-AUTHORIZED PAYMENT PLAN

Attach voided
sample check.

30. Request for Pre-Authorized Payment Plan

Policy Number(s)	Name(s) of Person(s) Insured	First Bank Withdrawal Effective			Type of Payment and Amount	
		month	day	year	Premium	Loan

By completing this section, I hereby authorize and request The Company to draw checks (which may include withdrawals made electronically) monthly on my account to pay premiums, and/or repay loans on the policies listed above or any policies subsequently designated.

I understand and agree that:

- a) Such checks (which may include withdrawals made electronically) shall be drawn monthly to pay premiums falling due on the designated policies.
- b) While the Pre-Authorized Payment Plan is in effect, The Company will not give notices of premiums falling due on such policies.
- c) The Pre-Authorized Payment Plan may be terminated by the bank depositor or by written notice to The Company by the Owner. If the Pre-Authorized Payment Plan is terminated, premiums falling due thereafter shall be payable directly to The Company as provided in the policy.
- d) The first premium paid must be submitted by check.

DECLARATIONS

The Proposed Life Insured(s) and Owner (or Parent or Guardian) declare that the statements and answers in this application and any form that is made part of this application are complete and true to the best of my/our knowledge and believe they are correctly recorded.

In addition, I/we understand and agree that:

1. The statements and the answers in this application, which include coverage details and any supplemental form relating to health, aviation practices or lifestyle of the Proposed Life Insured(s), will become part of the insurance policy issued as a result of this application.
2. a) **Any life insurance policy issued as a result of this application will be effective on the later of the date the first premium has been paid in full and the date the policy has been delivered, provided that since the date of the application there has been no deterioration in the insurability of the Proposed Life Insured(s), no changes in the lifestyle of the Proposed Life Insured(s), no change in the financial circumstances of the Owner, and nothing has occurred that would require a change to any statement or answer in any part of this application in order to make the statement or answer true and complete as of the date the policy becomes effective.**
If there has been a deterioration in insurability: i) if there is no Temporary Life Insurance Agreement (TIA) coverage, the policy will not be put into effect, and ii) if there is TIA coverage and the TIA has not ended, the policy will be put into effect but only to the limit of the TIA coverage amount.
- b) If premiums are paid prior to delivery of the policy and the terms and conditions of the TIA are satisfied, insurance prior to the effective date shall be provided only under the TIA and according to its terms.
3. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
4. If coverage under a TIA is applied for, I/we have received, read and understand the terms and conditions of the **Temporary Life Insurance Receipt and Agreement NB5004**.

OWNER/TAXPAYER CERTIFICATION QUESTIONS

U.S. Person(s) (including U.S. Resident/Alien(s))

Under the penalties of perjury, I the Owner, certify that:

1. The number shown on Page 1 of the application is my correct taxpayer identification number (if number has not been issued, write "Applied for" in the box on Page 1), AND
2. Pick the applicable box:
 - I am not subject to Backup Tax Withholding because (a) I am exempt from Backup Tax Withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to Backup Tax Withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to Backup Tax Withholding, OR
 - The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid Backup Tax Withholding.

Non U.S. Person(s) and Non Resident Alien(s)

I am providing IRS Form W-8BEN. Yes No

AUTHORIZATION TO OBTAIN INFORMATION

I/We, the Proposed Life Insured(s), authorize:

1. The Company to obtain an investigative consumer report on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me/us or any minor child/children who is/are to be insured.

The information collected by The Company may relate to the examination, diagnosis, treatment or prognosis of any physical or mental condition.

I/We further authorize The Company to disclose such information and any information developed during its evaluation of this application to:

(a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me/us; (d) me/us; (e) my/our insurance agent, when that agent is seeking insurance coverage through The Company on my/our behalf; (f) any medical professional designated by me/us; or (g) any person or entity entitled to receive such information by law or as I/we may further consent.

I/We acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc.

This authorization will be valid for two years from the date of the application shown below. A photocopy of this authorization will be as valid as the original.

Information collected under this authorization will be used by The Company to evaluate my/our application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am/We are entitled, or my/our authorized representative is entitled, to a copy of this authorization.

SIGNATURES

Please read all of the above Declarations and Authorizations before signing this form.

If Proposed Life Insured(s) is under age 18 Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year	
Signature of Owner (Signing Officer please provide title or corporate seal)			Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 18)			
X			X			
			Signature of Proposed Life Insured Two if other than Owner			
			X			
Agent signature	Signature of Agent/Registered Representative			Signed this	Day of	Year
X						



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

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

Complete and submit with Application for Life Insurance. Print and use black ink.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

AGENT QUESTIONS

To be completed by the Agent/Registered Representative.

3. a) Total Premium Collected: \$ _____ b) Has a Temporary Life Insurance Agreement been issued? Yes No
4. a) Question No. 8 of the application asks if there is, or if the applicant is considering entering into, an understanding or agreement providing for any person or entity, other than the Owner and beneficiaries specified in the application, to have any right, title or other legal or beneficial interest in any policy issued on the life of the Proposed Life Insured(s) as a result of the application. Examples of such an understanding or agreement include, but are not limited to, arrangements where the proposed Owner has or will have an option to sell to a third party the Owner's interest in the policy, or where a third party has or will have an option to buy the proposed Owner's interest in the policy. With this understanding, has Question No. 8 been answered appropriately?
 Yes No - give details _____
- b) Will any policy issued on the life of the Proposed Life Insured(s) as a result of this application, replace a policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity? Yes No
- c) Will the premiums, now or in the future, be funded by a loan or other means from someone other than the Insured or the Insured's employer? No Yes - give details of the funding arrangement. If applicable, describe the name of the lender, interest rate, term of loan, other fees, charges or other consideration to be paid on maturity of loan and required amount and type of collateral.

5. Will any entity other than a life insurance company be medically evaluating the Proposed Life Insured(s) to determine life expectancy or to otherwise obtain financing? No Yes - give details _____
6. a) Will this insurance replace existing policies or is the owner considering using funds from existing policies to pay premiums due on the new policy or contract? Yes No If Yes, the Agent/Registered Representative is required to present and read **IMPORTANT NOTICE: Replacement of Life Insurance or Annuities (Standard Form), NB5017** to the Owner. The completed form must be submitted with the Application.
- b) If Accident and Sickness or Long Term Care is being replaced, please give the Proposed Life Insured the **Notice for Replacement of Individual Accident and Sickness or Long-term Care Insurance, NB5019**.

c) List any other health insurance policies you have sold to the applicant.	Health policies in force	Health policies sold in the past 5 years and no longer in force

7. a) Did you see each Proposed Life Insured when the application was completed? Yes No - If 'No', answer question 7 b).
- b) Please describe how the application was solicited and completed.

8. a) Will this policy be owned by the employer of the Proposed Life Insured(s)? Yes No - If 'Yes', answer questions 8 b) & 8 c).
- b) The Proposed Life Insured(s) has received written notice, which: (i) indicates that the employer intends to insure the employee's life; (ii) specifies the maximum face amount for which the employee could be insured at the time the policy is issued; and (iii) informs the insured that the employer will be the beneficiary of the policy. Yes No
- c) The Proposed Life Insured(s) has provided written consent to being insured and that such coverage may continue after the employment relationship terminates. Yes No

9. Agent Information

Name of Agent/Entity	Agent Code	Social Security No.	Telephone No.	E-mail Address	% Share

Name of Broker Dealer (if applicable) _____ **Total must equal 100%**

CERTIFICATION AND SIGNATURE

Agent/
Registered
Representative
for this policy
must sign this
form.

I declare that I have asked the Proposed Life Insured(s) and/or the Owner each question on the application. The answers have been recorded by me exactly as stated and I know of nothing affecting the insurability of the Proposed Life Insured(s) which is not fully recorded in this application.

I certify that the state approved Buyer's Guide and John Hancock Illustration have been given to the Owner no later than at the time the application was signed and that no sales material other than that approved by The Company has been used.

Signed at City State This Day of Year

Signature of Agent/Registered Representative

X



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

**Application Supplement:
Coverage Details – Universal Life
John Hancock Life Insurance Company (U.S.A.)**
(hereinafter referred to as The Company)

This form is part of the Application for Life Insurance for the Proposed Life Insured(s).
Print and use black ink. Any changes must be initialed by the Proposed Life Insured(s) and/or Owner.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

PREMIUMS

3. Frequency: Annual Semi-Annual Quarterly List Billed
 Pre-Authorized Payment Plan (Please complete either Pre-Authorized Payment Plan Section of the **Application for Life Insurance, NB5000** or **Request for Pre-Authorized Payment Plan, NB5087**)
 Other _____

PREMIUM NOTICES AND CORRESPONDENCE

4. Send Premium Notices to: (Select One)
 Owner Proposed Life Insured One Proposed Life Insured Two
 Other _____
Name _____
Street No. & Name, Apt. No., City, State, Zip Code _____

5. Send Correspondence to: (Select One)
 Same as Above
 Other _____
Name _____
Street No. & Name, Apt. No., City, State, Zip Code _____

ADDITIONAL INFORMATION

6. If an additional or optional policy is being applied for in a separate application, state plan and amount:
_____ \$ _____
Plan Name _____
7. Do you understand that you may need to pay premiums in addition to Planned Premium if the current policy charges or actual interest credited are different from the assumptions used in your illustration (assuming the requirements of any applicable guaranteed death benefit feature have not been satisfied)? Yes No

LIFE INSURANCE QUALIFICATION TEST AND DEATH BENEFIT OPTION

8. Select One: Guideline Premium Cash Value Accumulation
Note: Elected test cannot be changed after the policy is issued. You may request an illustration on both tests before making your election.
9. Death Benefit Option: Option 1 (Face Amount/TFA) Option 2 (Face Amount/TFA plus Policy Value)

COVERAGE SELECTION

UNIVERSAL LIFE – SINGLE LIFE

Protection UL-G – Face Amount \$ _____

Choose one product from Coverage Selection section.

10. Select the Policy Protection Rider listed in the illustration's Coverage Summary section.

- Policy Protection Rider (6% Fixed Loan Rate)
- Policy Protection Rider - Flex (6% Fixed Loan Rate)
- Policy Protection Rider - Quick (6% Fixed Loan Rate)
- Policy Protection Rider - Enhanced (6% Fixed Loan Rate)
- Policy Protection Rider - Cash Value Advantage (Variable Loan Rate)

11. Additional Benefits:

- Cash Value Enhancement
- Disability Payment of Specified Premium: Monthly Specified Premium Amount \$ _____
- Return of Premium Death Benefit Rider (with DB1 only)
 - Increase rate Yes _____ % No
 - Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
- Accelerated Death Benefit (For terminal illness)
- LifeCare Benefit Rider (Please complete **LifeCare Benefit Rider, NB5018**)
- Other _____

UNIVERSAL LIFE – SINGLE LIFE continued

Accumulation UL – Total Face Amount \$ _____

12. Base Face Amount (if less than Total Face Amount) \$ _____

13. Supplemental Face Amount (SFA) (Check only one, if desired)

- Level SFA of \$ _____ for the life of the policy
- Initial SFA of \$ _____ for the life of the policy
- Increasing by: _____ % or \$ _____ per year for _____ policy years (level thereafter)
- Customized Increasing Schedule (List by policy year. SFA decreases cannot be scheduled at issue. Please complete **Customized Schedule, NB5064.**)

14. Additional Benefits:

- Overloan Protection Rider
- Cash Value Enhancement
- Enhanced Surrender Value Rider
- Total Disability Waiver of Monthly Deductions
- Return of Premium Death Benefit Rider (with DB1 only)
 - Increase rate Yes _____ % No
 - Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
- Accelerated Death Benefit (For terminal illness)
- LifeCare Benefit Rider (Please complete **LifeCare Benefit Rider, NB5018**)
- Other _____

Performance UL – Total Face Amount \$ _____

15. Base Face Amount (if less than Total Face Amount) \$ _____

16. Supplemental Face Amount (SFA)

- Level SFA of \$ _____ for the life of the policy
- Other _____

17. Additional Benefits:

- Cash Value Enhancement
- Total Disability Waiver of Monthly Deductions
- Return of Premium Death Benefit Rider (with DB1 only)
 - Increase rate Yes _____ % No
 - Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
- Accelerated Death Benefit (For terminal illness)
- LifeCare Benefit Rider (Please complete **LifeCare Benefit Rider, NB5018**)
- Other _____

COVERAGE SELECTION continued

Choose one product from Coverage Selection section.

UNIVERSAL LIFE – SURVIVORSHIP LIFE

Protection SUL-G – Face Amount \$ _____

18. Select the Policy Protection Rider listed in the illustration's Coverage Summary section.

- Policy Protection Rider
- Policy Protection Rider – Enhanced
- Policy Protection Rider – Flex

19. Additional Benefits:

- Cash Value Enhancement
- Return of Premium Death Benefit Rider (with DB1 only)
 - Increase rate Yes _____ % No
 - Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
- Disability Payment of Specified premium
 - Life One – \$ _____ Life Two – \$ _____
- Four Year Term (EPR)
- Policy Split option
- Other _____

Performance SUL – Total Face Amount \$ _____

20. Base Face Amount (if less than Total Face Amount) \$ _____

21. Supplemental Face Amount (SFA) (Check only one, if desired)

- Level SFA of \$ _____ for the life of the policy
- Initial SFA of \$ _____ for the life of the policy
 - Increasing by: _____ % or \$ _____ per year for _____ policy years (level thereafter)
- Customized Increasing Schedule (List by policy year. SFA decreases cannot be scheduled at issue. Please complete **Customized Schedule, NB5064NY.**)

22. Additional Benefits:

- Cash Value Enhancement
- Return of Premium Death Benefit Rider (with DB1 only)
 - Increase rate Yes _____ % No
 - Percentage of Premiums to be returned at death (Whole numbers only. Maximum 100%) _____ %
- Four Year Term (EPR)
- Policy Split option
- Other _____

OTHER

23. Select One: Single Life _____ Face Amount \$ _____ Survivorship Life _____ Face Amount \$ _____

SIGNATURES

If Proposed Life Insured(s) is under age 18 Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year
Signature of Owner (Signing Officer please provide title or corporate seal)			Signature of Proposed Life Insured One if other than Owner (Parent or Guardian if under age 18)		
X			X		
			Signature of Proposed Life Insured Two if other than Owner		
			X		

Agent signature

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



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Temporary Life Insurance Receipt and Agreement
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.

RECEIPT

The Company
acknowledges receipt of \$ _____

paid in connection with the
Application for Life Insurance dated _____
month day year

on **PROPOSED LIFE INSURED (LIFE ONE)**

PROPOSED LIFE INSURED (LIFE TWO)

1. Name _____
First Middle Last

2. Name _____
First Middle Last

3. Name of Owner _____

month day year **X**
Signature of Agent/Registered Representative

TEMPORARY LIFE INSURANCE AGREEMENT

This Temporary Life Insurance Agreement is hereby entered into as follows:

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AND SENT TO THE SERVICE OFFICE ADDRESS. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

The Company will pay a death benefit to the beneficiary named in the application if the Proposed Life Insured, or the Surviving Proposed Life Insured under a survivorship plan, dies while this Agreement is in effect, subject to the terms and conditions set out below.

- 1. WHEN AGREEMENT APPLIES.** No coverage will be provided under this Agreement if any of the following apply:
 - (a) any of the questions in the Temporary Life Insurance Agreement Application are answered "Yes" or left blank; or,
 - (b) any Proposed Life Insured is under age 20 or over age 70 (nearest birthday) as of the date that this Temporary Life Insurance Receipt and Agreement is signed by the Agent/Registered Representative ("the Effective Date"); and,
 - (c) the amount applied for under the above referenced Application for Life Insurance is more than \$10,000,000 of individual coverage or \$15,000,000 of survivorship coverage.
- 2. LIMITED AMOUNT OF INSURANCE.** The amount of Temporary Life Insurance coverage provided by The Company will be the lesser of:
 - (a) the amount of insurance applied for including supplementary benefits and accidental death benefit; or,
 - (b) \$1,000,000 for individual coverage or \$5,000,000 for survivorship coverage.
 This maximum amount of coverage applies to the total amount under this Agreement and any other Temporary Life Insurance Agreement with The Company covering the Proposed Life Insured. If there are two or more persons proposed for insurance, this maximum amount applies to the total coverage.
- 3. ACCIDENTAL DEATH BENEFIT LIMITATION.** If the benefits applied for include an accidental death benefit, no such benefit will be paid in respect of a death caused by:
 - (a) voluntarily taking or absorbing of any drug, medicine, sedative or poison (except in connection with any Proposed Life Insured's employment) unless prescribed by a licensed doctor other than the Proposed Life Insured; or,
 - (b) travel in any aircraft other than as a passenger.
- 4. DATE INSURANCE BEGINS.** Insurance under this Agreement will begin on the Effective Date if The Company's application for life insurance has been completed and a payment has been received by The Company for at least one-twelfth of the annual premium for the base plan and any supplementary benefits requested in the application. If payment is made by check or draft, no insurance will be provided by this Agreement unless the check or draft is honored when first presented for payment.
- 5. TERMINATION AND REFUND OF PREMIUM.** Insurance under this Temporary Life Insurance Agreement will end on the earliest of:
 - (a) the 90th day after the date of this Agreement;
 - (b) the day before the date insurance takes effect under the policy applied for;
 - (c) the date The Company mails notice to the applicant either declining to offer insurance to the applicant or offering insurance on a basis other than as applied for.

Upon termination of this Temporary Life Insurance Agreement, The Company's only liability will be to refund the premium paid without interest.

- 6. SUICIDE.** If any person proposed for insurance, whether sane or insane, commits suicide, The Company's only liability will be to refund the premium paid without interest.
- 7. MISREPRESENTATION.** If there is any material misrepresentation in the Temporary Life Insurance Agreement Application, The Company's only liability will be to refund the premium paid without interest.
- 8. OTHER CONDITIONS.** No one is authorized to change or waive any provision of this Agreement.

Give this page to the Owner



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

Financial Worksheet for Personal Insurance
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.

Complete this form based on the following Proposed Life Insured(s) age and face amount.

Ages 0-65: \$7,500,001+

Ages 66-79: \$5,000,000+

Ages 80-90: \$1,000,000+

PROPOSED LIFE INSURED(S)

LIFE ONE

1. a) Name _____
First Middle Last

b) Date of Birth _____
month day year

LIFE TWO

2. a) Name _____
First Middle Last

b) Date of Birth _____
month day year

INCOME INFORMATION

If total line applied for with John Hancock is \$10,000,000 or more, we require documentation of asset values.

We retain the right to require additional documentation and/or financial & tax statements for verification as needed.

3. a) Personal Income of Proposed Life Insured(s) (or Household in case of a Joint Life Application)

Earned Income	Past Year	Two Years ago	Unearned Income	Past Year	Two Years ago
Salary	\$	\$	Dividends	\$	\$
Bonus or Commission	\$	\$	Interest	\$	\$
Spouse/Family Earned Income	\$	\$	Rents	\$	\$
Other	\$	\$	Other	\$	\$
	\$	\$		\$	\$
	\$	\$		\$	\$
Total	\$	\$	Total	\$	\$

ASSETS AND LIABILITIES INFORMATION

4. a) Current net worth of the Proposed Life Insured(s). (Household if applicable)

Life One \$ _____ Personal Family Life Two \$ _____ Personal Family

If joint assets held, how much life insurance is inforce for spouse: \$ _____

b) Please provide breakdown of the assets and liabilities

For any item representing over 25% of your total assets, we require copies of latest statements of values.

Assets	
Description	Amount
Cash in Banks	\$
Stocks, Bonds, Securities	\$
Accounts Receivable	\$
Life Insurance (Cash Value)	\$
Personal Property	\$
Real Estate (Total)	\$
Other Assets	\$
	\$
Total	\$

Liabilities	
Description	Amount
Unpaid Interest & Taxes	\$
Notes Payable to Others	\$
Accounts Payable	\$
Life Insurance (Loans)	\$
Mortgages on Real Estate	\$
Other Long Term Debts	\$
Other Liabilities	\$
	\$
Total	\$



Summary and Disclosure Statement for Accelerated Benefit

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

(hereinafter referred to as The Company)

Name of Proposed Life Insured

Name of Owner (If other than the Proposed Life Insured)

Policy Number

This disclosure statement provides a brief description of the benefit available under the Accelerated Benefit Rider for an acceleration of your life insurance benefits. The full details of the benefit are included in the actual rider.

Description of the Accelerated Benefit

The Accelerated Benefit Rider provides for the payment of a portion of the death benefit under a life insurance policy to the policy owner if the life insured is terminally ill and has a life expectancy of one year or less. The accelerated benefit can only be paid once under the rider. There is no premium charged for the rider.

Conditions or Occurrences Triggering Payment of the Accelerated Benefit

Payment of the accelerated benefit is triggered by our receipt of written evidence satisfactory to us that the life insured is terminally ill and has a life expectancy of one year or less. Part of the evidence must be a written statement from a licensed medical doctor stating the prognosis for the illness.

Effect on Policy if an Accelerated Benefit is Paid

1. **Death Benefit:** The death benefit of your policy will be reduced by the accelerated benefit paid, plus one year's interest, plus any administrative expense charge.
2. **Cash Value:** The cash value of your policy will be reduced. The reduced cash value will be equal to the result of the original cash value multiplied by the death benefit remaining after the accelerated benefit is paid, divided by the death benefit before the accelerated benefit is paid.
3. **Policy Debt:** If your policy has a loan against it, the policy loan will be reduced by the same proportion as the cash value.
4. **Premium:** There is no change to the premium payable for your policy.

Receipt of the Accelerated Benefit is intended to qualify for favorable tax treatment under section 101(g)(1)(A) of the Internal Revenue Code of 1986 as amended by Public Law 104-191. However, receipt of the benefit may affect eligibility for Medicaid and certain other public assistance programs. You should consult with your personal tax advisor and social service agencies before you decide to receive the benefit.

I/We acknowledge that I/we have received and read this Summary and Disclosure Statement for the Accelerated Benefit.

Signatures

Signed at

This

Day of

Year

Signature of Agent / Registered Representative
X

Signature of Proposed Life Insured
X

Signature of Owner (If other than Proposed Life Insured)
X

HEALTH QUESTIONS continued

LIFE ONE

9. d) List by name, address and medical specialty, any Medical Specialists you have been referred to, consulted or treated by in the last 5 years.

LIFE TWO

10. d) List by name, address and medical specialty, any Medical Specialists you have been referred to, consulted or treated by in the last 5 years.

e) List any medications (prescription or non-prescription) you are taking currently.

e) List any medications (prescription or non-prescription) you are taking currently.

Please provide details to 'Yes' answers in questions 16 & 17.

11. Within the last 10 years, have you been told by a physician that you have had or have:

- a) Chest pain, shortness of breath, heart murmur, high blood pressure, Transient Ischemic Attack (TIA), stroke, irregular heart beat, or any other disease or disorder of the heart or arteries?
- b) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?
- c) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
- d) Arthritis, gout, or any bone, joint, muscle or skin disorder?
- e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
- g) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
- h) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
- i) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
- j) Cancer or tumors of any kind, malignant or benign?
- k) Any other health impairment or medically treated condition?

12. Within the last 10 years have you had:

- a) an operation or admission to a hospital or any other health care facility for observation and/or treatment of any illness or disease?
- b) any diagnostic tests, including a treadmill stress test for any purpose, including insurance, whether conducted on an in-patient or out-patient basis?

13. Within the last 10 years have you been diagnosed or treated by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?

14. Within the last 10 years have you:

- a) used amphetamines, barbiturates, cannabis (marijuana), cocaine, hallucinogens, opiates or any prescription drug except in accordance with physician's instructions?
- b) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a support group?

15. Do you:

- a) currently have any medical concerns for which you have not consulted a physician or had any consultation, testing or investigation recommended by a physician which has not yet been completed?

- b) consume alcoholic beverages?

Complete if **Currently** was selected in 15. b)

Complete if **In the past** was selected in 15. b)

Life One		
<input type="checkbox"/> Never <input type="checkbox"/> Currently <input type="checkbox"/> In the past		
Type of beverage	Frequency	Quantity
Date Stopped _____ month _____ year _____		
Reason Stopped _____		

Life Two		
<input type="checkbox"/> Never <input type="checkbox"/> Currently <input type="checkbox"/> In the past		
Type of beverage	Frequency	Quantity
Date Stopped _____ month _____ year _____		
Reason Stopped _____		

Life One	Life Two
<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	<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
<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	<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
<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	<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
<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



Service Office:
 Life New Business
 197 Clarendon Street
 Boston MA 02116-5010

IMPORTANT NOTICE:
Replacement of Life Insurance or Annuities (Standard Form)
John Hancock Life Insurance Company (U.S.A.)
 (hereinafter referred to as The Company)

This Important Notice must be read to the Owner. It must be signed by the Owner and the Agent/Registered Representative and a copy of the signed form left with the Owner. This Notice must be submitted with the Application for Life Insurance.

PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

3. I do not want this notice read aloud to me. _____ (Owner must initial only if this instruction applies.)
Initials

REPLACEMENT

Complete for all applicable policies to be replaced.

A **REPLACEMENT** occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, borrowed from an existing policy, forfeited, assigned to the replacing insurer, or otherwise terminated.

Please complete the following:

INSURANCE COMPANY _____ **POLICY NUMBER** _____

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) 1035 Exchange? Yes No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

Continue list on another page if you have more than 3 existing policies.

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) 1035 Exchange? Yes No

INSURANCE COMPANY _____ **POLICY NUMBER** _____

- a) Insured(s) _____
- b) Owner _____
- c) Issue Date _____
month day year
- d) Group Personal Business
- e) Annuity Life Term Endowment
- f) 1035 Exchange? Yes No

Make sure you know the facts. Contact your existing company or its agent/registered representative for information about the old policy. (If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent/registered representative in the sales presentation. Be sure that you are making an informed decision.

AGENT'S STATEMENT

4. The existing policy or contract is being replaced because

REMINDER TO AGENT/REGISTERED REPRESENTATIVE: John Hancock's policy concerning replacement appears in the "Agent's Code of Conduct" and states: The "Replacement" of existing policies should only occur when it is demonstratively in the best interest of the client and in compliance with all applicable state and Company requirements. You must disclose all of the advantages and disadvantages of any replacement. The client must fully understand the financial consequences of this action and, where required by regulation, Company policy or industry practice, consent to it in writing. You must indicate on every application for new coverage whenever a replacement is involved in that sale.

REPLACEMENT ISSUES

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the cost and benefits of your existing policy and the proposed policy. One way to do this is to ask the company or agent that sold you your existing policy to provide you with information concerning your existing policy. This may include an illustration of how your existing policy is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies. You should discuss the following with your agent/registered representative to determine whether replacement or financing your purchase makes sense.

PREMIUMS

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid. You will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY

- If your health has changed since you bought your old policy, the new one could cost you more, or your application could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS

- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (Ask your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

COMPARISON OF EXISTING AND PROPOSED POLICY

ALL questions must be answered.

7. In comparison with the existing policy, indicate the appropriate answer to the following questions. On the new policy:

- a) Is the guaranteed death benefit higher? Yes No Not applicable
- b) Are the guaranteed cash values higher? Yes No Not applicable
- c) Is the guaranteed interest rate higher? Yes No Not applicable
- d) Is the face amount higher? Yes No Not applicable
- e) Is the annual premium lower? Yes No Not applicable
- f) Is the loan interest rate lower? Yes No Not applicable
- g) Is the underwriting classification more favorable? Yes No Not applicable
- h) Will any ownership problems be resolved? Yes No Not applicable
- i) Will any beneficiary problems be resolved? Yes No Not applicable

You have a "free-look" period within which to examine the proposed policy. If you are not satisfied, you can return it for a full refund within the period stated in the new policy.

CAUTION

If, after studying the information made available to you, you decide to replace the existing life insurance with our life insurance policy, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or you may only be able to purchase it at substantially higher rates.

SIGNATURES

The information and responses given to the questions in this form are, to the best of my knowledge, accurate.

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

Name of Owner (Please print)

Signature of Owner

X

Name of Agent/Registered Representative as Witness (Please print)

Signature of Agent/Registered Representative as Witness

X

ADDITIONAL OWNERS SIGNATURES IF MULTIPLE OWNERS

If additional Owner signatures required please attach additional page including Owner name, date and signature.

Name of Owner (Please print)

Signature of Owner

X

month | day | year

Name of Owner (Please print)

Signature of Owner

X

month | day | year



LIFE INSURANCE

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

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

Must be signed by Grantor(s) and Trustee(s)

PROPOSED LIFE INSURED(S)

LIFE ONE

LIFE TWO

- 1. a) Name (First, Middle, Last)
3. Name of Trust (The Trust)
4. Name(s) of Grantor(s)
5. Name(s) of Trustee(s)
6. a) Nature of the relationship between the Grantor(s) and the Trustee(s) b) Duration of relationship
7. Who are the current beneficiaries of the Trust?
8. a) Effective Date of Trust (month, day, year) b) Date Trust was signed/executed (month, day, year) c) Situs of Trust: The trust is subject to the laws of the State of
9. Address of Trust (Street No. & Name, Suite No., City, State, Zip code)
10. Did you retain an attorney to prepare the trust document? [] Yes [] No (We will not contact the attorney without your written approval.)
If 'Yes', name and address of attorney.
If 'No', name and address of provider.
Name of Attorney/Provider
Address of Attorney/Provider (Street No. & Name, Suite No., City, State, Zip code)

CERTIFICATION

- 11. The Grantor(s) and Trustees(s) declare and represent to The Company that the answers provided in this Trust Certification are accurate and complete and also certify that:
a) the Trust is: [] Irrevocable and is in full force and in effect; [] Revocable and is in full force and in effect;
b) the Trustee(s) is/are allowed by the terms of the Trust to purchase Life Insurance and Securities;
c) the Trust permits the Trustee(s) to exercise all ownership rights provided by the Policy issued by The Company to the Trust, including, but not limited to, the right to surrender, pledge or encumber the Policy or make withdrawals and the Trustee(s) is/are permitted to distribute the Policy to any beneficiary of the Trust or to sell and transfer ownership of the Policy pursuant to the sale;
d) neither The Company or anyone acting as an agent of The Company is responsible to determine the authority of the Trustee(s) or inquire into, or review the provisions of the Trust, and shall not be charged with knowledge of the terms of the Trust; and
e) The Company may rely on the evidence submitted with respect to any change of the Trustee(s) and/or the appointment of a successor Trustee, and is not responsible to determine that the change or the appointment of any additional or successor Trustee(s) conforms with the Trust provisions.
f) Beneficial interests under the Trust can and will only be established for persons who (i) are related to the Proposed Life Insured(s) by blood or by law, (ii) have a substantial interest in the Proposed Life Insured(s) engendered by love and affection, or (iii) hold a lawful and substantial economic interest in the continued life of the Proposed Life Insured(s).

SIGNATURE

Signed at City State This Day of Year
Signature of Agent/Registered Representative (as Witness) X Signature of Grantor X
Signature of Grantor X
Signature of Trustee X Signature of Trustee X



Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

EXTERNAL 1035 Exchange
Absolute Assignment/Beneficiary Change
John Hancock Life Insurance Company (U.S.A.)
(hereinafter referred to as The Company)

EXISTING POLICY(IES)
PROPOSED LIFE INSURED(S)

LIFE ONE

1. Name _____
First Middle Last

LIFE TWO

2. Name _____
First Middle Last

3. Existing Policy(ies) issued by _____
Company Name

Complete one form per Issuing Company and Owner.

Confirm original policy has been lost or destroyed. If trust owned, provide full name of trust and name(s) of trustee(s), including date of trust.

Proposed Life Insured		Policy Number	Policy Lost or Destroyed		Owner	Is there a loan on the existing policy?		If 'Yes' do you wish to transfer the loan?	
Life One	Life Two		Yes	No		Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EXCHANGES TO NEW POLICY

WHEREAS the undersigned desires to exchange the above referenced Existing Policy(ies) under Section 1035 of the Internal Revenue Code, NOW THEREFORE, in consideration for The Company agreeing to issue a new policy (the "New Policy") in exchange for the Existing Policy(ies),

1. Upon final approval of the undersigned's application for the New Policy, the undersigned:
 - a) Assigns and transfers absolutely all right, title and interest in the above referenced Existing Policy(ies) to:
 John Hancock Life Insurance Company (U.S.A.)
 PO Box 55765
 Boston MA 02205-5765
 Attention: LIFE NEW BUSINESS
 - b) Authorizes The Company to file this Absolute Assignment / Beneficiary Change with the Existing Insurer, and do everything that is required to accomplish the surrender of the Existing Policy(ies) for the cash surrender value.
 - c) Names The Company as beneficiary under the Existing Policy(ies), revoking any prior beneficiary designations.

If a proposed life insured dies prior to the final approval of the undersigned's application for the New Policy, this Absolute Assignment / Beneficiary Change is void and of no effect.

2. The undersigned warrants that each Existing Policy is free and clear of any liens or prior assignments and is not subject to any bankruptcy or collection proceedings.
3. The undersigned understands and agrees that:
 - a) Coverage under the New Policy shall not become effective until the later of the date the first premium has been paid in full and the date the New Policy has been delivered, subject to all of the terms and conditions of the New Policy.
 - b) If the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the assignment of the above referenced Existing Policy(ies) to The Company according to this Absolute Assignment / Beneficiary Change, The Company will pay a death benefit to the beneficiary named in the application for the New Policy equal to the lesser of (i) the amount of insurance applied for under the New Policy, or (ii) the total amount of death proceeds that would have been payable under the above referenced Existing Policy(ies), subject to all of the terms and conditions of the Existing Policy(ies). If the Existing Insurer rescinds any of the above referenced Existing Policy(ies) or otherwise dishonors this Absolute Assignment / Beneficiary Change or the Company's surrender request with respect to any Existing Policy(ies), the amount of death proceeds that would have been payable under such Existing Policy(ies) will not be included in the calculation of the total amount of death proceeds set forth in (ii) above.
 - c) If the proposed life insured, or the surviving proposed life insured under a survivorship plan, dies prior to the effective date of coverage of the New Policy but after the assignment of the above referenced Existing Policy(ies) to The Company, any amounts paid by the Existing Insurer under the Existing Policy(ies) to a claimant other than The Company shall be deducted from the amount owed to the beneficiary named in the application for the New Policy under the provisions set forth in paragraph b) above.

EXCHANGES TO NEW POLICY continued

4. The undersigned is responsible for and agrees to pay any and all premium payments that may come due prior to the assignment of the Existing Policy(ies), which is effective upon final approval of the undersigned's application for the New Policy, in accordance with the terms of such Existing Policy(ies).
5. The undersigned agrees that notwithstanding this Absolute Assignment / Beneficiary Change, the Existing Insurer shall be responsible for: 1) the failure to properly calculate the values of the Existing Policy(ies); 2) the delay or failure in paying surrender values to The Company; and 3) the failure or delay in providing to The Company the accurate cost basis, Modified Endowment Contract ("MEC") status, and income tax gain information on the Existing Policy(ies). The Company shall have no obligation or liability relating to or arising from these responsibilities.
6. The undersigned understands and agrees that at any time prior to the transmittal of this Absolute Assignment / Beneficiary Change to the Existing Insurer requesting the surrender of the Existing Policy(ies) for the cash surrender value, The Company may release this Absolute Assignment / Beneficiary Change and reassign ownership of the Existing Policy(ies) to the undersigned.
7. If the undersigned should subsequently decide to cancel the application for the New Policy or return the New Policy under the "free look" provision, The Company will release this Absolute Assignment / Beneficiary Change. It is understood that in the event of the cancellation of the application or return of the New Policy under the "free look" provision, the undersigned may not be able to return the cash surrender proceeds to the Existing Insurer and/or reinstate the Existing Policy(ies) as most insurance policy contracts do not extend the right of reinstatement if a policy was surrendered. If The Company has already requested the surrender of any Existing Policy(ies), The Company's only obligation hereunder shall be the return of all premiums received. Such refund of premiums shall be paid, at the direction of the undersigned, either to the undersigned or to the Existing Insurer.
8. The Company is furnishing this form and is participating in this transaction at the undersigned's specific request, as an accommodation to the undersigned. The undersigned states and agrees that The Company makes no representations concerning the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise, and The Company has no responsibility or liability for the validity of this Absolute Assignment / Beneficiary Change nor the undersigned's tax treatment under Section 1035 of the Internal Revenue Code or otherwise.
9. The undersigned understands that any outstanding loan(s) on any Existing Policy(ies) at the time of the assignment that is not transferred and applied to the New Policy may be reported to the Internal Revenue Service by the Existing Insurer as a distribution and will be taxable up to the amount of gain in such Existing Policy(ies) immediately prior to the assignment.

SIGNATURES

Signed at	City	State	This	Day of	Year
Signature of Agent/Registered Representative as Witness				Signature of Owner (if corporation, officer(s) and title(s) must be indicated)	
X				X	
				Signature of Owner (if corporation, officer(s) and title(s) must be indicated)	
				X	

CONFIRMATION - FOR INTERNAL USE ONLY

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

This	Day of	Year	Signature of Company Official
			X