John Hancock
LIFE INSURANCE

Informal Inquiry

John Hancock Life Insurance Company U.S.A.

(hereinafter referred to as The Company)

This is not an application for life insurance. It is a preliminary assessment of insurability.

PROPOSED LIFE INSURED

1. a) Name _____ b) Sex ☐ M ☐ F
   First Middle Last

   c) Date of Birth (Month Day Year) _____ d) Height _____ ft. _____ in. e) Weight _____ lbs.

   f) Telephone Nos. Personal _____ Business _____

   g) Citizenship ☐ U.S. ☐ Other - _____ h) If not a US resident, provide Country _____

   i) Primary Residence _____
   Street Address City State Zip Code

   j) Tobacco Use ☐ No ☐ Yes - Specify Type - _____ Date Last Used (Month Year) _____

   k) Occupation _____ ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

   l) Employer _____

   m) Gross Income Earned $ _____ Unearned $ _____

   n) Net Worth $ _____ ☐ Personal ☐ Joint with Spouse

COVERAGE INFORMATION

2. a) Face Amount $ _____ b) Policy Type ☐ Individual ☐ Survivorship ☐ Perm ☐ Term

   c) ☐ Long Term Care Rider d) State of Issue _____

   e) Proposed Premium $ _____ ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Premium

   f) Current total life insurance in-force $ _____

   g) Date Last Purchased (Month Day Year) _____ Was policy rated? ☐ No ☐ Yes

   h) Is this insurance replacing existing insurance? ☐ No ☐ Yes

   i) Is this a 1035 Exchange? ☐ No ☐ Yes

   j) Have you ever been declined or rated for insurance?
   ☐ No ☐ Yes - give details

   _____

FAMILY HISTORY

3.

Family Health	Age (If deceased, age at death)	History of heart disease or circulatory disorder	History of cancer, all types
a) Mother		☐ No ☐ Yes	☐ No ☐ Yes
b) Father		☐ No ☐ Yes	☐ No ☐ Yes
c) Sisters		☐ No ☐ Yes	☐ No ☐ Yes
d) Brothers		☐ No ☐ Yes	☐ No ☐ Yes

GENERAL RISK AND LIFESTYLE - Please check all that apply and provide details in Q 6.

4 a) ☐ Cardiovascular ☐ Heart ☐ Angina ☐ Stroke ☐ HBP

b) ☐ Cancer - Type _____

c) ☐ Diabetes ☐ Type 1 ☐ Type 2

d) ☐ Drug Abuse ☐ Alcohol Abuse

e) Other medical ☐ Mental/Nervous ☐ Respiratory ☐ Urinary ☐ Gastrointestinal

5 a) ☐ Personal bankruptcy

b) ☐ Residence outside of US or Canada _____

c) Hazardous avocations _____

d) Private aviation _____

e) Driving record ☐ DWI/DUI ☐ Violations

f) Other _____

6. Details

Question No.	Details

PHYSICIAN INFORMATION

7 a) Primary Physician _____

b) Phone No. _____

c) Date Last Consulted Month Day Year

d) Reason for visit _____

e) Diagnosis _____

f) List of medications _____

g) Address _____
Street Address City State Zip Code

8 a) Name of Specialist _____

b) Phone No. _____

c) Date Last Consulted Month Day Year

d) Reason for visit _____

e) Address _____
Street Address City State Zip Code

Service Office:
Life New Business
27 Drydock Ave
Boston MA 02210-2377

HIPAA Compliant Authorization
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 Insured.

PROPOSED INSURED

1. a) Name _____ b) Date of Birth _____

First Middle Last month day year

AUTHORIZATION

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

I authorize the following people or entities to disclose my Protected Health Information (as defined below): any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years; any insurance company (including The Company or its affiliates) or agent from which I have applied for or obtained insurance; and any consumer reporting agency, such as the Medical Information Bureau, Inc. (MIB) and any other entity or person having Protected Health Information about me.

Such disclosure of my Protected Health Information may be to The Company, its affiliated companies, agents, service providers, reinsurers, or MIB.

"Protected Health Information" includes:

1. my entire medical record, medical history, prescription history, medications prescribed and any other health information concerning me;
2. information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases;
3. information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes; or
4. genetic information and genetic test results, to the extent permitted by law.

My Protected Health Information is to be used and disclosed under this Authorization for the following purposes with respect to any insurance coverage, including but not limited to life insurance and/or long-term care insurance, that I have or have applied for with The Company or its affiliates:

1. make underwriting, eligibility, risk rating, policy issuance and enrollment determinations;
2. obtain reinsurance;
3. administer coverage;
4. determine responsibility for, and to the extent obligated, pay claims and benefits;
5. determine whether incorrect, incomplete or misrepresented information was provided for purposes of evaluating a policy rescission or claims contest investigation, including with respect to insurance coverage not covered under HIPAA;
6. conduct other legally permissible activities.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to The Company at the above Service Office address, Attention: Chief Underwriter. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest a policy itself. I understand that if any of my Protected Health Information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

By my signature below, I acknowledge that any agreements I have made to restrict my Protected Health Information do not apply to this Authorization. I authorize any of the entities or persons referred to above to release and disclose my Protected Health Information without restriction, including any Protected Health Information containing genetic information or genetic test results to the extent permitted by law.

I further understand that if I refuse to sign this Authorization, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any claim or benefit payments. I understand that I or any authorized representative will receive a copy of this Authorization.

SIGNATURE

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

X _____

Signature of Proposed Insured _____ Print Name _____

John Hancock
LIFE INSURANCE

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

Authorization to Obtain Information

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).

PROPOSED LIFE INSURED LIFE ONE

Name	First	Middle	Last

PROPOSED LIFE INSURED LIFE TWO

Name	First	Middle	Last

AUTHORIZATION TO OBTAIN INFORMATION

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

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me/us.
2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, the MIB, Inc. or any other similar person or organization to give The Company and its reinsurers information about me/us or any minor child/children who are to be insured. The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition.
3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to give The Company and its reinsurers financial/net worth information about me/us.

I/We authorize The Company to disclose such information and any information developed during its evaluation of my/our 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 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 - If Proposed Life Insured(s) is under age 15, Parent or Guardian must sign and include relationship.

Signed at	City	State	This	Day of	Year

X

Signature of Proposed Life Insured One
(Parent or Guardian if under age 15)

X

Signature of Proposed Life Insured Two

X

Signature of Agent/Registered Representative