New Business Transmittal

Transmittal Date

Mailing Address
Attn: Life New Business
John Hancock Insurance Services
PO Box 55765
Boston, MA 02205-5765

Overnight Courier
Attn: Life New Business
John Hancock Insurance Services
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Firm

☐ Formal ☐ Informal Query (IQT)

New Business Firm Contact

New Business Firm Contact	Phone Number	Fax Number
E-mail Address	Street Address	
Is this a Wholesaling case? ☐ No ☐ Yes	Broker Dealer	

Producer

Producer Name - First and Last		
SSN	**John Hancock Producer Code**	
In relation to this insurance application, can we contact the Producer directly? ☐ No ☐ Yes	Phone Number	Fax Number

IMPORTANT: To avoid delays in processing this application, please ensure that the producer is properly LICENSED with the applicable John Hancock company in the state where this application is being solicited.

Proposed Insured

Proposed Insured (1) Name	Proposed Insured (2) Name	
In relation to this insurance application, can we contact the Proposed Insured directly? ☐ No ☐ Yes	Phone Number	Best time to call

Attachments – Mark (x)

- ☐ Authorization
- ☐ Cover Letter
- ☐ Non-Med
- ☐ Avocation Questionnaire
- ☐ Signed Proposal
- ☐ Replacement Forms
- ☐ 1035 Forms
- ☐ Temporary Insurance Agreement
- ☐ Premium Check
- ☐ Certified TIN
- ☐ Trust Document
- ☐ Fund Allocation
- ☐ Agent Report
- ☐ Other (Specifics)

Medical Requirements

- ☐ EKG
- ☐ APS
- ☐ TST
- ☐ Para-Med

Outstanding Requirements – Mark items already ordered with (x) and indicate the Service Provider.

- ☐ Authorization
- ☐ Cover Letter
- ☐ Non-Med
- ☐ Avocation Questionnaire
- ☐ Signed Proposal
- ☐ Replacement Forms
- ☐ 1035 Forms
- ☐ Temporary Insurance Agreement
- ☐ Premium Check
- ☐ Certified TIN
- ☐ Trust Document
- ☐ Fund Allocation
- ☐ Agent Report
- ☐ Other (Specifics)

Medical Requirements	**Service Provider**
☐ Para-Med	
☐ Blood/micro	
☐ EKG/TST	
☐ X-Ray	
☐ APS	

John Hancock's Regional Director Name

Comments/ Special Handling Instructions

John Hancock

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

SmartProtect Application for Individual Life Insurance

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Sex ☐ Male ☐ Female

3. Primary Residence STREET ADDRESS CITY STATE ZIP CODE

4. Date of Birth MONTH DAY YEAR

5. Social Security Number

6. Place of Birth STATE/COUNTRY

7. Driver's License Number/State ☐ I do not have a driver's license

8. Telephone Numbers PERSONAL BUSINESS

9. Email Address

10. Occupation

☐ Job/Duties _____ Employed by _____

☐ Retired ☐ Unemployed ☐ Student ☐ Other _____

11. Are you currently a member of the armed forces, including the reserves?

☐ Yes ☐ No ! *If Yes, complete Military Personnel Financial Services Disclosure Regarding Insurance Products NB5109*

12. Gross Annual Household Income

Salary $ _____ Other $ _____

13. Household Net Worth

$ _____

14. Purpose of Insurance

☐ Income Replacement ☐ Estate Planning ☐ Other - give details _____

SECTION B: Policy Owner

- Complete if Policy Owner is someone other than the Proposed Insured
- List additional Policy Owners and details in *SECTION K: ADDITIONAL INFORMATION*

1. Who is the Policy Owner?

☐ Spouse ☐ Other (list relationship) _____

2. Name FIRST MIDDLE LAST

3. Address STREET ADDRESS CITY STATE ZIP CODE

4. Date of Birth MONTH DAY YEAR

5. Social Security Number

6. Telephone Number

7. Email Address

8. Multiple Policy Owners - Type of Ownership ☐ Joint with right of survivorship ☐ Tenants in common

SECTION C: Beneficiary Information

- This section is to be completed by Policy Owner
- Beneficiary listed in Q.1 is always assigned as Primary
- List additional beneficiaries in *SECTION K: ADDITIONAL INFORMATION*

1. a. Name FIRST MIDDLE LAST

b. Percentage _____ %

c. Relationship to Proposed Insured
☐ Spouse ☐ Child ☐ Other _____

d. Date of Birth
MONTH DAY YEAR

e. Social Security Number

f. Telephone Number

g. Email Address

h. Address STREET ADDRESS CITY STATE ZIP CODE

2. a. Name FIRST MIDDLE LAST

b. Percentage _____ %

c.
☐ Primary
☐ Secondary

d. Relationship to Proposed Insured
☐ Spouse ☐ Child
☐ Other _____

e. Date of Birth
MONTH DAY YEAR

f. Social Security Number

g. Telephone Number

h. Email Address

i. Address STREET ADDRESS CITY STATE ZIP CODE

SECTION D: Coverage Details

1. Face Amount: $ _____

2. Product
   a. ☐ SmartProtect Term with Vitality
   Term Period (select one)
   ☐ 10 Years ☐ 15 Years ☐ 20 Years
   b. ☐ Other _____

3. Riders and Benefits (optional)
   ☐ Accelerated Death Benefit (For Terminal Illness)

SECTION E: Purpose and Funding Information

- This section is to be completed by Policy Owner
- All Premium Notices and Correspondence are sent to the Policy Owner at the address provided in Section B

1. a. Billing Method

☐ Pre-Authorized Payment Plan ! *Complete Request for Pre-Authorized Payment Plan NB5087*

☐ Direct Bill (not available for monthly billing)

b. Please select billing frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (Pre-Authorized Payment Plan only)

2. Does the Policy Owner have any existing life insurance and/or annuity policies or contracts? ☐ Yes ☐ No

! *If Yes, the appropriate state Replacement forms must be completed and submitted with this application*

3. Does the Policy Owner plan on replacing, discontinuing, or changing any life insurance policy with the policy you are now applying for? ☐ Yes ☐ No

! *PLEASE NOTE: While the intent of this limited program is to apply for additional coverage, certain replacements of existing coverage are permitted. However, tax-free exchanges of insurance policies under Section 1035 of the Internal Revenue Code are not supported through this program, and thus a replacement may have adverse tax consequences to you. If considering a replacement, please consult with your tax advisor.*

4. a. Is the Proposed Insured under this application also an insured on any other existing life insurance policy or does the Proposed Insured have formal applications pending with any other company? ☐ Yes ☐ No

! *If you checked Yes, complete question 4b.*

b. If Yes, provide details for each existing and pending life insurance policy on the Proposed Insured with all companies.

INSURANCE COMPANY	STATUS		AMOUNT	ISSUE YEAR	PURPOSE		TO BE REPLACED	
	EXISTING	PENDING			PERSONAL	BUSINESS	YES	NO
	☐	☐	$		☐	☐	☐	☐
	☐	☐	$		☐	☐	☐	☐

5. Lapse Notification Handling

Secondary Addressee: In addition to the Policy Owner, The Company will mail lapse notices for overdue premiums to any Secondary Addressee you designate. If you want this option, provide the following information for the Secondary Addressee:

a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

c. Address STREET ADDRESS CITY STATE ZIP CODE

SECTION F: Personal Information

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

1. The information you provide in this application is critical to our consideration of your request for insurance coverage. You are strongly urged to answer all questions completely and accurately so that we may provide you with the best coverage we can. We will seek information from other sources to assist us with evaluating your application, potentially including your health care provider. If your answers are incorrect, incomplete or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage. Please know that your personal information, including health information, is protected by The Company and only used by The Company to do business with you, and as permitted or required by law.

   X _____ Initial here to acknowledge that you have carefully reviewed and fully understand the above statement.

2. a. Primary Physician Name FIRST LAST ☐ Check if Proposed Insured does not have a physician

   b. Address STREET ADDRESS CITY STATE ZIP CODE c. Telephone Number

3. Date of last visit MONTH DAY YEAR

4. Reason for last visit, outcome and treatment prescribed

5. Provide your height: _____ feet _____ inches

6. Provide your weight: _____ lbs.

7. Have you had any weight loss or gain of 10 lbs. or more in the past 12 months for reasons other than intentional diet or exercise?

   ☐ Yes – specify lbs.: _____ Lost _____ Gained

   ☐ No

8. What was your last blood pressure reading? _____ / _____ ☐ Check if unknown

9. What was your last cholesterol reading? Total Cholesterol: _____ HDL Ratio: _____ ☐ Unknown

10. Describe your complete tobacco/nicotine products usage history, including but not limited to: cigarettes, e-cigarettes, cigars, pipe, chewing tobacco, snuff, hookah, nicotine patch, nicotine gum.
    NOTE: Tobacco use does not automatically nor necessarily result in denial of coverage.

• *If products used exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF PRODUCT	QUANTITY AND UNIT (Ex. Packs, cigarettes, patches, etc.)	FREQUENCY	DATE LAST USED (MONTH/YEAR)
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	
	# _____ Unit Type _____	☐ Day ☐ Month ☐ Year	

☐ I have never used nicotine/tobacco products

11. Describe your marijuana use in the past 5 years.

PURPOSE
☐ Recreational/Social
☐ Medicinal – Provide Prescription Card ID _____

Date Last Used MONTH YEAR

FREQUENCY
_____ times per ☐ Day ☐ Month ☐ Year

DELIVERY METHOD
☐ Ingested ☐ Vaporized ☐ Inhaled

☐ I have not used marijuana in the past 5 years

SECTION F: Personal Information *continues on next page*

SECTION F: Personal Information (continued)

12. Family History: *Please provide the following details concerning your biological family history to the best of your knowledge.*

FAMILY MEMBER	• Indicate any diagnosis and age of onset (i.e. diagnosis age) if any of your immediate family members have ever been diagnosed by a member of the medical profession with Cancer, Coronary Artery Disease, Stroke, Diabetes, Huntington's, Alzheimer's, or Polycystic Kidney Disease. • Provide health status/medical condition if living.	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS/SISTERS ☐ No siblings				

13. Describe your present alcohol consumption.

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

If consumption exceeds the allotted space below, list remainder in SECTION K: ADDITIONAL INFORMATION

TYPE OF BEVERAGE	AMOUNT (# OF DRINKS) AND FREQUENCY	DATE LAST USED (MONTH/YEAR)
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR

☐ I have not consumed alcohol in the past 10 years

14. In the past 10 years have you been advised to limit or discontinue alcohol use, or sought or received counseling or treatment by a medical professional for alcohol use?	☐ Yes ☐ No
15. Within the last 10 years have you used, or tested positive for:	
a. Cocaine, heroin, amphetamines, or hallucinogens?	☐ Yes ☐ No
b. Tranquilizers, sedatives or narcotic drugs or any prescription drug except those used in accordance with physician's instructions?	☐ Yes ☐ No
16. In the past 10 years have you been sought or received counseling or treatment by a medical professional for drug use?	☐ Yes ☐ No

17. If YES to questions 14, 15 or 16, please provide details:

SECTION G: Medications

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

1. List all medications you have taken or been prescribed in the last 12 months and the conditions for which they are being taken.

PRESCRIPTION NAME	CONDITIONS FOR WHICH THIS MEDICATION IS TAKEN

☐ I have not been prescribed any medications in the last 12 months

SECTION H: Medical Conditions

• Any information that requires more space or further detail can be added in *SECTION K: ADDITIONAL INFORMATION*

1. In the last 5 years, have you been diagnosed, treated or consulted with a member of the medical profession for any of the following medical conditions? *Check all that apply*

a. ☐ Coronary Artery Disease ☐ Heart Attack ☐ Cardiac Chest Pains ☐ Arrythmia/Irregular Heart Beat ☐ Heart Murmur/Valvular Heart Disease ☐ Other Disorders of the Heart or Blood Vessels	☐ None of these apply to me
b. ☐ Peripheral Vascular Disease ☐ Stroke ☐ Transient Ischemic Attack (TIA)	☐ None of these apply to me
c. ☐ Diabetes ☐ High Blood Sugar ☐ Glucose Intolerance ☐ Pre-diabetes	☐ None of these apply to me
d. ☐ Alzheimer's Disease/Dementia ☐ Cognitive Impairment/Memory Loss ☐ Bipolar Disorder ☐ Major Depression ☐ Other Mental Nervous Disorders (i.e.: Psychosis, Schizophrenia)	☐ None of these apply to me
e. ☐ Epilepsy/Seizure Disorder ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Paralysis ☐ Parkinson's Disease	☐ None of these apply to me
f. ☐ Chronic Obstructive Pulmonary Disease/Chronic Bronchitis/Emphysema ☐ Sarcoidosis	☐ None of these apply to me
g. ☐ Barrett's Esophagus ☐ Cirrhosis ☐ Hepatitis B or C ☐ Kidney Disease ☐ Pancreatitis	☐ None of these apply to me
h. ☐ Cancer/Malignancy (excluding Basal Cell and Squamous Cell skin cancers) ☐ Familial Polyposis	☐ None of these apply to me
i. ☐ Anemia (excluding mild iron deficiency)/Blood Disorders ☐ Autoimmune Disorders ☐ Connective Tissue Disease ☐ Rheumatoid Arthritis	☐ None of these apply to me

SECTION H: Medical Information *continues on next page*

SECTION H: Medical Conditions (continued)

2. In the last 5 years, have you been diagnosed, treated or consulted with a member of the medical profession for any of the following medical conditions?
   Check all that apply and provide complete details.

MEDICAL CONDITIONS

a. ☐ High Blood Pressure
   ☐ High Cholesterol
   ☐ Disorders of the Thyroid or Other Glands
   ☐ Asthma
   ☐ Sleep Apnea
   ☐ Anxiety
   ☐ Mild Depression
   ☐ None of these apply to me

b. ☐ Osteoarthritis
   ☐ Osteoporosis
   ☐ Other Bone, Joint, or Muscle Disorders
   ☐ None of these apply to me

c. ☐ Benign Tumor
   ☐ Crohn's/Ulcerative Colitis
   ☐ Mild Iron Deficiency Anemia
   ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

SECTION I: Medical Conditions and Diagnostic Tests

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

- For questions 1, 2, and 3, you do not need to tell us about: muscle strains, sprains, or limb fractures that you have fully recovered from, normal childbirth, colds, flu, appendicitis, seasonal asthma, vasectomy, tonsillitis, conjunctivitis, or hay fever
- Provide complete details to any Yes responses
- If you need more space for information, please continue to *SECTION K: ADDITIONAL INFORMATION*

1. Completed Diagnostic Testing: Within the past 2 years have you undergone any diagnostic tests (e.g.: CT Scan, MRI, screening tests for family history) other than HIV or routine screening tests (i.e. Blood, Urine, EKG), whether conducted on an inpatient or outpatient basis?

   ☐ Yes ☐ No

   If Yes, give details _____

2. Pending Tests or Procedures: In the past 5 years have you been advised by a member of the medical profession to have any surgery, procedure, treatment or diagnostic testing (including any screening tests for family history but excluding those for HIV), other than for routine screening purposes that have not yet been completed or results of which have not yet been received?

   ☐ Yes ☐ No

   If Yes, give details _____

3. Other than what has already been asked, within the last 5 years have you been treated, consulted, or given medical advice by a member of the medical profession in any hospital, emergency room, urgent care or medical facility for any disease, disorder, symptoms, or injury not previously mentioned?

   ☐ Yes ☐ No

   If Yes, give details _____

4. As far as you know, have you been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS-related conditions?

   ☐ Yes ☐ No

   If Yes, give details _____

SECTION J: Lifestyle

• This section is to be completed by Proposed Insured as it pertains to his or her own personal history

1. Describe your exercise routine, such as walking, running, treadmill, swimming, aerobics, strength training, cycling, sports or yoga.

   • *If exercises exceed the allotted space below, list the remainder in SECTION K: ADDITIONAL INFORMATION*

TYPE OF EXERCISE	FREQUENCY	TIME SPENT PER SESSION
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3 x/week ☐ 4-6 x/week	_____ hours _____ minutes

☐ I do not participate in an exercise routine

2. Have you ever had an application for life insurance declined, postponed, modified, requiring extra premium, or offered less than applied for by any company?

   ☐ Yes ☐ No

   If Yes, give details of decision type, reason and date _____

SECTION J: Lifestyle *continues on next page*

SECTION J: Lifestyle (continued)

3. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?
   ☐ Yes ☐ No
   If Yes, give details of location (city/country), purpose, frequency and duration _____

4. Have you ever flown or do you intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes?
   ☐ Yes ☐ No

5. Please indicate any of the following activities you participate in or have participated in, within the last 2 years:
   ☐ Motor vehicle racing ☐ Scuba diving ☐ Power boat racing ☐ Motorcycle racing ☐ Mountain climbing
   ☐ Hang-gliding ☐ Skydiving/Parachuting ☐ Base Jumping ☐ Backcountry skiing/snowmobiling
   ☐ I do not participate in any of these activities
   ❗ *If any activities selected, complete Avocation Questionnaire NB5010*

6. Please indicate which of the following apply to your driving history:
   ☐ Convicted of 1 or more moving violations in the past 2 years ☐ Convicted of driving while intoxicated or otherwise impaired
   ☐ License is currently revoked or suspended ☐ None of these apply to me

SECTION K: Additional Information

QUESTION NUMBER	DETAILS

SECTION L: Special Requests

DECLARATIONS

The Proposed Insured and Policy Owner 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 their knowledge and belief. All such statements and answers are representations, not warranties.

In addition, I/we understand and agree that:

1. **Policy Application:** The statements and answers in this application, including any supplemental form related to health, aviation practices or lifestyle of the Proposed Insured, will become part of the insurance policy issued as a result of this application. No information about me will be considered to have been given to The Company unless it is stated in the application or any form that is made part hereof.
2. **Policy Effective Date:**
   - **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 to the Policy Owner, provided that the Proposed Insured is still living and nothing has occurred that would require a change in any statement or answer in any part of the application, including any supplemental forms, in order to make the statement or answer true and complete as of the date this policy becomes effective. If there has been such an occurrence, the policy will not be put into effect.
   - **b)** Only an officer of The Company may make, modify, or discharge any insurance contract on its behalf. No agent has the authority to: (i) accept risks; (ii) determine insurability; (iii) make or modify any contractual provision; or (iv) waive any of The Company's rights or requirements.
3. **Fraud Warning:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
4. **Variable Policies: I/We acknowledge that the policy values that are based on the separate account assets are not guaranteed and will decrease or increase with investment experience.** I/we acknowledge receipt of the current prospectuses and supplements that describe the variable life insurance policy applied for and the sub-accounts of the separate account that are available under this policy. I/We have reviewed the prospectuses and supplements and believe that the variable life policy is consistent with my/our insurance needs, investment objectives and investment risk tolerance.
5. **Flexible Premium Policies**: I/We understand that I/we may need to pay additional premiums in addition to the Planned Premium if the current policy charges or actual interest rate credited/investment performance are different from the assumptions used in the illustration (assuming the requirements of any applicable guaranteed death benefit feature have not been satisfied).
6. **Vitality Benefit:** If a policy is issued with a Vitality (Healthy Engagement rider) or benefit (the "Benefit"), the Proposed Insured will receive a membership in a healthy engagement program offered by a third party program provider. By applying for the Benefit, the Proposed Insured authorizes The Company to share his/her personal information, including certain health information, with the provider in connection with the registration for the program and administration of the Benefit.
   The Proposed Insured understands and agrees that (i) his/her program membership will be subject to the provider's privacy policy and terms and conditions of membership, which the Proposed Insured should read prior to joining the program, and (ii) he/she will be asked to authorize the provider to share his/her health, lifestyle, medical or other personal information with The Company. The Proposed Insured will not be eligible to participate in the program if the terms and conditions of membership are not accepted. Upon termination of the policy or rider, as applicable, the program membership will terminate and access to further benefits and incentives, if any, will cease as provided in the terms and conditions.
   The Company is not responsible or liable for any damage, loss or injury arising out of the Proposed Insured's participation in any third party healthy engagement programs or receipt of any products or services provided through such programs.

Read carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me.

2. Any medical professional, medical care provider, hospital, clinic, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, the MIB, Inc. ("MIB") or any other similar person or organization to disclose health information about me. Health information includes: (i) my entire medical record and medical history, prescription history, and other health information; (ii) confidential information related to Human Immunodeficiency Virus (HIV), other communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to disclose financial/net worth information about me.

Such disclosure of my information may be made to The Company, its affiliated companies, agents, service providers, reinsurers, MIB or any person or entity entitled to receive such information by law or as I may further consent.

Information collected under this authorization will be used to evaluate my application for insurance, identify any misrepresentation in the information provided by me in this application, administer coverage, evaluate a claim for benefits, for reinsurance or other insurance purposes, or to conduct other legally permissible activities. I authorize The Company, or its reinsurers, to make a brief report of my health information to MIB.

This authorization is valid for 24 months from the date shown below or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter. A photocopy of this authorization will be as valid as the original. I am entitled, or my authorized representative is entitled, to a copy of this authorization.

I understand that I can revoke this permission to collect information at any time by providing written notification to John Hancock Life Insurance Company (U.S.A.) at the Service Office address (page 1) Attention: Chief Underwriter, but any revocation will not affect such information that has already been collected and relied on by The Company.

I acknowledge receipt of the Notice of Disclosure of Information related to the underwriting process, investigative consumer reports and the MIB.

SIGNATURES

X _____

SIGNATURE OF POLICY OWNER

_____

POLICY OWNER - SIGNED AT CITY STATE THIS DAY OF YEAR

X _____ _____

SIGNATURE OF PROPOSED INSURED IF OTHER THAN POLICY OWNER DATE

AGENT/REGISTERED REPRESENTATIVE SIGNATURE

I certify that all information supplied by the Proposed Insured/Owner has truly and accurately been recorded on the application to the best of my knowledge and belief.

X _____ _____

SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE DATE

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

SmartProtect Agent Report

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.
To be completed by the Agent/Registered Representative and submitted with SmartProtect Application for Life Insurance.

SECTION A: Proposed Insured

LIFE ONE
1. Name FIRST MIDDLE LAST

SECTION B: General Information

2. Is there, or is the Owner 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 Insured as a result of the Application? ☐ Yes ☐ No

SECTION C: Existing and Replacing Insurance

3. Does the Policy Owner plan on replacing, discontinuing, or changing any life insurance policy with the policy now being applied for? ☐ Yes ☐ No

PLEASE NOTE: While the intent of this limited program is to apply for additional coverage, certain replacements of existing coverage are permitted. However, tax-free exchanges of insurance policies under Section 1035 of the Internal Revenue Code are not supported through this program, and thus a replacement may have adverse tax consequences.

SECTION D: Agent Information – Select only one servicing agent

4. a.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM	AGENT CODE

% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
100 %	☐ Yes			

b.

NAME OF AGENT/ENTITY		BROKER DEALER/BGA FIRM	AGENT CODE

% SHARE	SERVICING AGENT	SOCIAL SECURITY NO.	TELEPHONE NO.	EMAIL ADDRESS
%	☐ Yes			

SECTION E: Certification and Signature

• An Agent/Registered Representative for this policy must sign this form

I know of nothing affecting the insurability of the Proposed Insured which is not fully recorded in the application submitted on the Proposed Insured.

I certify that the state approved Buyer's Guide, Notice of Disclosure of Information and any other disclosure notice, statement or information required by state or federal law were given to the Owner at the time of the application and that no sales material other than that approved by The Company has been used.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____
SIGNATURE OF AGENT/REGISTERED REPRESENTATIVE

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

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.

SECTION A: Proposed Insured

1. Name FIRST MIDDLE LAST

2. Date of Birth MONTH DAY YEAR

SECTION B: 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; electronic health record provider; 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.

SECTION C: Signature

SIGNED AT CITY STATE THIS DAY OF YEAR

X SIGNATURE OF PROPOSED INSURED

X PRINT NAME

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Request For Taxpayer Identification Number and Certification

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

(hereinafter referred to as The Company)

Please Read Instructions before Completing Form

- This form must be completed by each Owner who is a U.S. person, including a U.S. citizen, U.S. resident alien or other U.S. person. You may submit a completed IRS Form W-9 instead of this form. Please see the IRS instructions to Form W-9 for more information, including the definition of a U.S. person.
- If you are not a U.S. person, do NOT complete this form. Instead, please complete the appropriate Form W-8.
- Forms W-9, W-8 and their instructions are available at the IRS website **http:/www.irs.gov/Forms-&-Pubs**

OWNER/LIFE INSURED INFORMATION

1. a) Name of Life Insured(s)	b) Policy Number
c) Owner Name (as shown on your income tax return)	d) Telephone No. of Owner
e) Business Name/disregarded entity name, if different from above	
f) Owner Address Street Address / City / State / Zip Code	

FEDERAL TAX CLASSIFICATION

Please check appropriate box to indicate how you are taxed for federal income tax purposes:

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/Estate

☐ Limited Liability Company: Check the tax classification ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Other _____

Exemptions (see instructions on page 2)

☐ Exempt Payee Code (if any) _____

☐ Exemption from FATCA reporting code (if any) _____

TAXPAYER IDENTIFICATION NUMBER (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). For other entities, it is your employer identification number (EIN). If you have applied for a number and are waiting for one to be issued, please check the Applied For box below. You then have 60 days to submit a certified TIN in order to avoid backup withholding.

Social security number _____ Employer identification number _____ ☐ Applied For

CERTIFICATION

I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because:
   a. I am exempt from backup withholding, or
   b. I have not been notified by the Internal Revenue Services (IRS) that I am subject to backup 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 withholding, and
3. I am a U.S. citizen or other U.S. person (as defined in the instructions to Form W-9), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification Instructions

You must check the box below if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends.

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

Please note that by signing this form, you declare that you make the above certifications under penalties of perjury.

SIGNATURE

Under penalties of perjury, I certify the above statements.

X _____ _____

Signature of Owner (Provide title or corporate seal, if Signing Officer) Date

INSTRUCTION FOR EXEMPTION CODES

Some taxpayers are exempt from backup withholding and/or FATCA reporting. If you are exempt, please enter your exemption code(s) in the appropriate field in the Federal Tax Classification section. The codes are identified below. Sections cited below are from the Internal Revenue Code.

Exempt Payee Code

Taxpayers who are exempt from backup withholding should enter the applicable code from the following list. Generally, individuals, including sole proprietors, and personal trusts are **not** exempt from backup withholding.

1. An organization exempt from tax under section 501(a).
2. The United States or any of its agencies or instrumentalities.
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities.
5. A corporation
6. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States.
7. A futures commission merchant registered with the Commodity Futures Trading Commission.
8. A real estate investment trust.
9. An entity registered at all times during the tax year under the Investment Company Act of 1940.
10. A common trust fund operated by a bank under section 584(a)
11. A financial institution
12. A middleman know in the investment community as a nominee or custodian.
13. A trust exempt from tax under section 664 or described in section 4947.

Exemption from FATCA reporting code

The following codes identify payees exempt from reporting under the Foreign Account Tax Compliance Act. These codes apply to persons submitting this form for accounts maintained outside the U.S. by certain foreign financial institutions. **If you are submitting this form for an account you will hold in the United States, you may leave this field blank.**

A. An organization exempt from tax under section 501(a).

B. The United States or any of its agencies or instrumentalities

C. A state, the District of Columbia, a possession of the U.S., or any of their political subdivisions or instrumentalities.

D. A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i).

E. A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i).

F. A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options),registered as such under the laws of the U. S. or any state.

G. A real estate investment trust.

H. A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940.

I. A common trust fund as defined in section 584(a).

J. A bank as defined in section 581.

K. A broker.

L. A trust exempt from tax under section 664 or 4947(a)(1).

M. A tax exempt trust under a section 457(g) plan.

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Notice of Disclosure of Information

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

SECTION A: Proposed Insured(s)

LIFE ONE
1. Name FIRST MIDDLE LAST

LIFE TWO
2. Name FIRST MIDDLE LAST

SECTION B: Information Exchange

This brief description of our underwriting process is designed to help you understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others, and your right to learn the nature and substance of that information upon written request.

The purpose of the underwriting process is to make sure that you qualify for life insurance and if so, to establish the proper premium charge for that insurance. The information necessary to evaluate your application is dependent upon your age, the amount of insurance you are applying for, your medical history, your occupation, your avocations and other personal information. Your answers on the application are the principal source of information; however, additional sources of information may be required.

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Information for consumers about MIB may be obtained on its website at **www.mib.com**.

SECTION C: Investigative Consumer Report Notice

As part of our normal procedure, an investigative consumer report may be prepared concerning your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

On request to the Chief Underwriter, at the above Service Office address, we will disclose to you whether or not an investigative consumer report was done, the nature and scope of the report, a summary of consumer rights and the name and address of the consumer reporting firm from whom you may request a copy of the report.

SECTION D: Insurance Information Practices

The personal information we obtain about you is confidential and we will not disclose it to other parties without your written authorization except as permitted or required by law. You have the right to access the personal information about you that appears in our files, including any medical record information disclosed within three years of your request, unless that information relates to a claim or a civil or criminal proceeding.

However, we will normally give medical record information only to a licensed physician of your choice. You also have the right to seek correction of information about you that you believe to be inaccurate or incomplete. We will provide you with a more detailed explanation of our information practices and access and correction procedures if you send us a written request. You may do so by writing to the Chief Underwriter at the above Service Office address.

Please provide each Proposed Insured with a copy.

Customer Privacy Notice

OUR PRIVACY COMMITMENT TO YOU

John Hancock respects your privacy. Your trust is one of our most valuable assets. One way we hope to keep your trust is by properly protecting your personal information.

The law requires us to provide this notice to you annually. It describes our privacy policy and how we handle your personal information.

Why Do We Collect Your Personal Information?

Collecting personal information about you helps us provide you with quality products and services. It also helps us confirm your identity and prevent fraud. The type of information we collect depends on the product or service you have with us.

We obtain most of your personal information from you and from transactions and other interactions with you. This information may include:

- Personal data: name, address, email address, telephone number, date of birth, social security number and place of employment
- Financial data: income, assets, banking information and investment preferences
- Health data: medical and health-related information and habits
- Interaction data: data obtained when you visit or use our websites, mobile applications, or social media sites

We may also obtain information from third parties and publicly available sources. For instance, your insurance agent, broker, registered representative or financial advisor, consumer reporting agencies, medical providers, data service providers, and insurance support agencies such as the Medical Information Bureau, Inc. (MIB) may share information with us.

How Do We Protect The Personal Information We Have Collected About You?

We have administrative, physical and technical safeguards in place to protect your information. Our employees and associates respect your personal information and are trained to keep it safe. We take prompt action with those who do not follow our privacy rules relating to either past or current customers.

You should be aware that we will never ask for your personal information (such as account numbers, Social Security Numbers, or passwords) through an unsolicited email or phone call.

How Do We Use and Share The Personal Information We Have Collected About You?

All financial services companies need to use and share customers' personal information to run their business. We use and share your personal information as permitted or required by law:

- with employees and associates when their jobs require it to process and service your contracts, benefits or accounts
- with your financial advisor, representative, or firm in order for them to better serve you
- with third parties that perform services on our behalf. They are required to have information protection safeguards in place. They are contractually bound to use your information only to perform those services. They are not permitted to use or disclose your information for their own marketing purposes.
- with companies we purchase reinsurance coverage from
- to conduct routine or required activities like audits and tax filings
- to participate in research studies or to conduct surveys
- in response to subpoenas and court orders, or to comply with legal requests made by law enforcement and regulatory authorities

We will not sell to or share your information with any unaffiliated company for the purpose of that company marketing its products or services to you. We may share it with unaffiliated financial services companies to jointly sponsor or offer products or services to you.

We plan to share your information within the John Hancock affiliated companies in order to provide you with offers for other John Hancock products or services. You have a right to opt out of that information sharing.

How Can You Opt Out?

If you do not want us to share your personal information with our John Hancock affiliated companies for their own marketing purposes, you may opt out of that information sharing at **www.johnhancock.com/contactpreferences** or by calling 1-888-354-6461. Your request will take effect within 30 days. If you have more than one John Hancock product, you only need to opt out once. Once you opt-out, we will honor your choice until you ask us to change it. If you are the joint owner of a product and you tell us not to share information, your choice will apply to all owners of that product. If you have already exercised your right to opt out, there is no need to contact us again.

We will continue to send you information about your contracts, benefits, and accounts and may also include information about other John Hancock products or services. Opting out will not affect the ability of your financial advisor, representative, or firm to recommend products or services to you.

What Is Our Online Privacy Policy?

You may read our Online Privacy Statement at **www.johnhancock.com.**

How Can You Review Your Information?

Generally, you have the right to review personal information we have obtained about you. Requests to review your personal information must be made in writing and signed by you. The request must include:

- your full name
- address
- product type (e.g. life, annuity, etc.)
- policy contract or account number

If you believe that information we have obtained about you is incorrect, you may write us and request a correction. If we do not agree to your requested correction, we will let you know and you may write us to dispute our decision. We will keep all of your correspondence in our files.

Contacting Us

If you have a question about your policy, contract or account, or if you want to review the information we have on file about you, please contact us at:

Customer Service Center R-03
John Hancock
1 John Hancock Way Suite 1350
Boston MA 02217-1099

Telephone:
1-800-387-2747 John Hancock
1-888-267-7781 John Hancock Life Insurance Company of New York

If you have a question about this Privacy Notice, please contact the John Hancock Privacy Office.

Mailing Address: John Hancock Privacy Office
U.S. Compliance Department
P.O. Box 111
Boston, MA 02117

Email Address: **PrivacyQuestions@jhancock.com**

The John Hancock Family of Companies

John Hancock is a subsidiary of Manulife Financial Corporation. The following John Hancock companies provide this notice and/or may provide you with information about John Hancock's products and services:

- John Hancock Advisers, LLC
- John Hancock Distributors, LLC
- John Hancock Funds, LLC
- John Hancock Investment Management Services, LLC
- John Hancock Life & Health Insurance Company
- John Hancock Life Insurance Company (U.S.A.)
- John Hancock Life Insurance Company of New York
- John Hancock Retirement Plan Services, LLC
- John Hancock Signature Services, Inc
- John Hancock Trust Company, LLC
- Hancock Capital Investment Management, LLC
- John Hancock Personal Financial Services, LLC
- Manulife Asset Management (US) LLC
- Signator Investors, Inc.
- Signator Financial Services, Inc.
- Signator Insurance Agency, Inc. and its affiliated agents and agencies

You may obtain information about the Securities Investor Protection Corporation (SIPC), including a SIPC brochure, by contacting SIPC at **www.sipc.org** or 1-202-371-8300.

PS4089US (11/2015)