

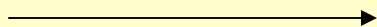
New Features:

- The new shaded design throughout the application allows you and your client to read and complete the more easily

- A number of benefit combinations and disclosures have been moved to the instruction pages making the application less congested

Optional Benefits have been segmented into three distinct sections:

- Partner and Family Benefits
- Additional Homecare Options
- Additional Benefit Protection Options



2005 Simplified Application

Control Number: _____

Application for Individual Long-Term Care Insurance
John Hancock Life Insurance Company

John Hancock

Note: Please initial any changes you make to this application. You may not make changes to dates or signatures.

Part 1 – Please Tell Us About Yourself

1a. Name (First, M.I., Last): _____ 1b. Male Female

1c. Street Address: _____
 City: _____ State: _____ Zip Code: _____

1d. SS#: _____ 1e. DOB (mm/dd/yyyy): ____/____/____ 1f. Birth Place (State, Country): _____

1g. Payor Name (if different from above): _____
 Billing Address: _____
 City: _____ State: _____ Zip Code: _____

1h. Height: _____ 1i. Weight: _____

1j. Best time to call: _____ Telephone No.: _____

Part 2 – Choose Your Coverage Asterisk (*) items are not available for ages 80-84.

2a. Custom Care II Benefit Amounts: (Choose either the Monthly or Daily Benefit Amount)
 Monthly Benefit Amount: \$ _____ \$1,500 - \$15,000 in \$100 increments (Limit of \$7,500 for ages 80-84)
 Daily Benefit Amount: \$ _____ \$50 - \$500 in \$10 increments (Limit of \$250 for ages 80-84)

2b. Benefit Periods (Years): 2 3 4* 5* 6* 10* Lifetime*
(The Benefit Period is used to determine the Policy Limit shown on the Policy Schedule.)

2c. Elimination Period (Dates of Service): 30* 60* 90 180 365

2d. Inflation Protection Options:
 None
 5% Simple Inflation
 5% Compound Inflation (Benefit Amounts and Policy Limit increase at 5% compounded annually.)
 5%/3% Compound Inflation (Benefit Amounts increase at 5% compounded annually, while Policy Limit increases at 3% compounded annually. Therefore, your benefits may last for a shorter period of time than the Benefit Period you elected.)

2e. Rejection of Inflation Protection: (Please read. You must check the box below if you do not select Compound or Simple Inflation.)
 I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed the Compound and Simple Inflation options and I reject inflation protection.

2f. Optional Benefits:

Partner & Family Benefits

SharedCare* (Spouse/Partner Name) _____

Survivorship/Waiver

FamilyCare* Designate the additional family member(s) to be covered and in the order you wish them to succeed you as policyholder in the event of death or lapse. Each family member must complete the FamilyCare Supplemental Addendum and will be subject to Underwriting approval. Submit each Addendum with this Application.

1 _____
 2 _____ 3 _____

Additional Home Care Options

Waiver of the Home Care Elimination Period*

Additional Cash Benefit

Additional Benefit Protection Options

Restoration of Benefits*

Enhanced Return of Premium Upon Death* (Complete question 3a if you elected this benefit.)

Nonforfeiture

2g. Rejection of Nonforfeiture: (You must check the box below if you have not elected Nonforfeiture.)
 I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.

CC2APP05
1
Custom Care II

Partner Status Updated
from 5 to 3 years

Certain conditions have been
removed from the “Knock-Out”
Section to allow John Hancock
Long Term Care Underwriting to
further review and evaluate the
case.

These conditions include:

Cerebral Atrophy, Cirrhosis,
Crest, Diabetes with insulin
(regardless of units), Kidney
Failure, Metastatic Cancer,
Organic Brain Syndrome, Post
Polio Paralytic Syndrome and
TIAs (2 or more).

Part 3 – Discounts & Other Needed Information

Beneficiary Designation

3a. If you are age 64 or younger or elected the optional Enhanced Return of Premium Upon Death, you must elect a beneficiary. If you leave this question blank, we will designate your estate as your beneficiary. You may change your beneficiary at any time by notifying us in writing. (Name & Address): _____

You may be eligible for certain discounts. Please check YES or NO beside each numbered question or statement.

Marital/Partner Discount

3b. Are you married? Yes No

3c. If you are not married, are you in a committed relationship with a Partner or an immediate family member of the same generation, with whom you have been living together for at least the past 3 years? Yes No

3d. Is your Spouse, Partner or immediate family member of the same generation also applying for this insurance or does he/she currently have an existing John Hancock individual long-term care insurance policy? Yes No
If YES, provide info below: _____

Name: _____ Birthdate: / / _____ Policy # (if available): _____

Family Discount (Not available with the Sponsored Group Discount)

3e. Are you applying for a family discount? If YES, please list two other family members applying for, or who currently have a John Hancock individual long-term care insurance policy and their relationship to you. Yes No

Name: _____ Relationship: _____ Policy # (if available): _____

Sponsored Group Discount (Not available with the Family Discount)

3f. Do you belong to a sponsored group? Yes No

If YES, Sponsored Group #: _____ and Sponsored Group Name: _____

(Please also provide proof of employment/membership with sponsored group.)

Part 4 – Should You Proceed with this Application?

Please check YES or NO beside each question.

4a. Do you currently have, or have you ever had a diagnosis for:
Alzheimer's Disease Huntington's Chorea Multiple Sclerosis Schizophrenia
Amyotrophic Lateral Sclerosis Memory Loss Muscular Dystrophy Scleroderma
Cystic Fibrosis Mental Retardation Myasthenia Gravis Spinal Cord Injury
Dementia Multiple Myeloma Parkinson's Disease Stroke/CVA. Yes No

4b. Do you require human assistance or supervision in any of the following activities: eating, dressing, toileting, transferring from bed to chair, walking, maintaining continence, and bathing? Yes No

4c. Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care? Yes No

4d. Do you currently use one of the following medical devices: wheelchair, walker, hospital bed, quad cane, oxygen, stairlift, and dialysis? Yes No

4e. Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex? Yes No

PLEASE NOTE BEFORE YOU CONTINUE WITH THIS APPLICATION:

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

Part 5 - Continued

5i. **MEDICATIONS** – List all prescription medications taken at any time over the past 12 months.

Medication	Dosage	Frequency	Reason Prescribed	Physician Name

LIFESTYLE – Please complete the following questions if you are age 64 or younger.

- 5j. Are you currently employed? If so, what is your occupation: _____ Yes No
- 5k. In the past 10 years, have you done or do you intend to do any of the following activities: Skin/scuba diving, Parachuting, Motorized racing, Rock/mountain climbing, Boxing? If "Yes" frequency: _____ Yes No
- 5l. In the past 10 years, have you been convicted of two or more felony motor vehicle moving violations or had a driving license suspended or revoked? If "Yes", license number and state: _____ Yes No

Part 6 – Insurance History

Please check YES or NO beside each numbered question or statement.

- 6a. Are you covered by Medicaid? _____ Yes No
- 6b. Have you had another long-term care insurance policy or certificate in force during the last 12 months? If YES, please provide details below _____ Yes No
- 6c. Do you have another long-term care insurance policy or certificate in force (including a health care service, Health maintenance organization or Medicare Supplement contract)? If YES, please provide details below _____ Yes No
- 6d. Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying? If YES, please provide details below _____ Yes No

Company	Policy/Cert#	Annual Premium	Benefit Type & Amounts	Currently in Force?	If Lapsed, Date of Lapse	Is it being replaced?

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

Credit Card Payment Options
MasterCard and Visa
Incorporated. CC
Authorization form no
longer needed if this section
has been completed.

Part 7 – Payment & Administration

7a. **Payment Type:** You must choose one of the following options:

1. **Direct Bill** Select a payment frequency: Annually Semi-Annually Quarterly

Direct Bill Advance Payment:

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

(Please make all checks payable to John Hancock Life Insurance Company. Do not make check payable to the agent or leave the payee blank. The advance payment must be equal to a minimum of one month's premium. Your advance payment check will be held in a non-interest bearing account while we underwrite your application.)

2. **Bank Draft:**

Insured's Name: _____ Bank Account #: _____
Account Type: Checking Savings Bank Name: _____
Bank Routing Number: _____ Select Draft Day(1*-28*): _____
Name(s) of Depositor(s) _____
Please include a voided check. The first draft will occur on the premium due date after the policy has been issued. Subsequent drafts will occur on the selected draft day requested above.

3. **Credit/Debit Card:**

Payment Frequency: Quarterly Monthly
Card Type: Mastercard Visa
Card Number: _____ Expiration Date: _____
Cardholders Name: _____

4. **List Bill** List Bill Group #: _____ List Bill Group Name: _____

7b. **Limited Pay Options:**

10-year Payment Option or Paid-Up at 65 Payment Option (not available if applicant is older than 55)

If you choose any Limited-Pay Option, then the Guaranteed Purchase Option will not be available to you.

7c. **Special Requests:** _____

Part 8 – Protection Against Unintended Lapse

I understand that I have the right to designate another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. (You must check off one box below.)

8a. I elect NOT to designate any person to receive such notice.
OR

8b. I elect to designate the person below to receive such notice.

Name (First, M.I., Last): _____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Part 9 – Agreement & Acknowledgment

I agree as follows: My statements and answers on this application are true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

I understand that in order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete. In addition, John Hancock Life Insurance Company ("John Hancock") may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test. I understand that no agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.

For the purpose of underwriting my application, by making an advance payment with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. And, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen. I understand that completing this application or making an advance payment does not guarantee that my application will be approved. If my application is approved, the effective date of my policy will be stated in the policy issued to me. I understand that in order to keep my policy in force, I must pay all the required premiums when due. I understand that if my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.

Acknowledgments: I have received the policy Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure Form, the Shopper's Guide to Long-Term Care Insurance and a Replacement Notice (if replacement is involved). If eligible for Medicare, I have received the "Guide to Health Insurance for People with Medicare".

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

I authorize John Hancock to deduct from my bank or charge my credit/debit card the advance payment and all recurring required premiums, based upon my selected method of payment as shown in Part 7. I understand that the premiums deducted or charged will be as shown on the policy or the most recent premium change notice issued to the policyholder by John Hancock. This authorization is valid indefinitely until such time as I provide written notice of cancellation to John Hancock at the servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

I have reviewed this application including all elections and answers contained within. By my signature, I affirm all the elections and answers in this application.

Signature of Applicant

Date

Signed at:

City

State

Part 10 – Producer/Agent's Statement

Replacement:

To the best of my knowledge, replacement of other insurance is/ is not involved in this transaction. Listed below are all other health insurance policies I have (i) sold to the Applicant which are still in force; and (ii) sold to the Applicant in the last five years which are no longer in force.

Company	Type of Policy	Effective Date	In Force?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

Underwriting: Risk classification quoted: Preferred Select Class I (25%) Class II (50%)

Note: Underwriting will determine the best risk class, regardless of class quoted to the applicant. We will communicate any change to you.

Signature of Licensed Agent: _____

Agent Name (Please print): _____ Date: ____ / ____ / ____

Please attach the illustration presented to the Applicant.

Credit for Application

Producer/Agent Name (Please print): _____

Agency/Bank/Firm Name: _____

Social Security #: _____ Tel. #: _____

Annual Premium: \$ _____ Fax#: _____

JH Agency Code (if known): _____ Email: _____

JHFN Career Only: Payroll Number: _____

Contract Code: _____

If more than one agent was involved in the sale, provide details here:

Agent Name: _____ Percentage:

Agent SS#: _____

Agency/Firm: _____

Agent Name: _____ Percentage:

Agent SS#: _____

Agency/Firm: _____

Agent Name: _____ Percentage:

Agent SS#: _____

Agency/Firm: _____

Attach producer/agent's
business card here

Home Office Only: