

Authorization Form for John Hancock to Accept Credit Card Payments for Long Term Care Insurance

Applicant/ Policyholder Name: _____

Applicant/ Policyholder Tax ID Number or Social Security Number: _____

Policy Number (if applicable): _____

Type of Credit Card: MasterCard Visa

Mode of Payment: Monthly Quarterly

Card Holder Name: _____

Card Holder Address: _____

City: _____ State: _____ Zip: _____

Phone Number: Day () _____ Evening () _____

Credit Card Number: _____

Expiration Date: Month _____ Year _____

I authorize John Hancock to deduct from my credit card the advance payment and all recurring required premiums, based upon my selected method of payment shown on this form. I understand that the premiums 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.

Card Holder Signature: _____ Date: _____

For credit card inquiries please contact Customer Access: 1(800) 377-7311

Please return authorization form to:

New Business policies: Send form with application or with 1064 form for reissues

Inforce policies: LTC Policyholder Services/ X-5

One John Hancock Way, Suite 1700

Boston, MA 02217-1700

Available only for new Custom Care II and Essential Care II policies in states where approved.
Available for Custom Care I and Essential Care I in California and Florida only.