New Business Insurance Transmittal

Transmittal Date

Mailing Address - Toronto
John Hancock
Attn: New Business
Service Center - ST3
P.O. Box 4608
Buffalo NY 14240-4608

Courier Address - Toronto
John Hancock
Attn: New Business Service Center - ST3
200 Bloor Street East
Toronto ON
Canada M4W 1E5

Mailing Address - Boston
John Hancock
Attn: Life New Business
and Underwriting - C-5
197 Clarendon St
Boston MA 02117

Firm

☐ Formal ☐ Informal Query (IQT)

Please complete the following section for Business Planning Cases ONLY

Plan Administrator

Pangburn: ☐ Yes ☐ No

Payor Company

Purpose of Insurance

☐ Executive Bonus Plan
☐ REBA
☐ Deferred Compensation SERP
☐ Deferred Compensation Salary Deferral
☐ Split Dollar:
☐ Collateral Assignment ☐ Endorsement
☐ Key Person
☐ Buy-Sell:
☐ Redemption ☐ Purchase

New Business Firm Contact

New Business Firm Contact	Phone Number	Fax Number
E-mail Address	Street Address	Broker Dealer

Producer

Producer Name - First and Last	SSN
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 APPOINTED 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 or Policy Detail Form
- ☐ 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 or Policy Detail Form
- ☐ 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

Instructions for Application for Life Insurance

This kit is for John Hancock new business only, excluding John Hancock New York.

1. Do You Have the Correct Form?

The application form must be taken in the state where solicitation took place. The state where the application is signed (taken) is deemed to be the state of solicitation. For more details, see State of Issue - Law Applicable guidelines in the New Business section on www.jhsalesnet.com.

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.

2. Buyer's Guide

- A Buyer's Guide must be given to the Owner at time of Application.
- Please visit www.jhsalesnet.com for instructions on how to choose the correct Buyer's Guide.

3. Avoid Delays

- Ensure each form includes the name of each Proposed Life Insured.
- Answer ALL questions. Any changes must be initialed by the Proposed Insured and/or Owner (as applicable).
- Complete Life Two information if spousal or survivorship coverage is required.
- Complete the HIPAA Compliant Authorization (form NB5025) if John Hancock is responsible for requesting Attending Doctor Statements.
- Ensure that the application reflects all of the elected features shown on the illustration. No information will be used from the illustration directly.
- Include the face amount of any policy that has been assigned or sold when answering question number 10 about Existing and Pending Insurance.

4. Temporary Life Insurance

Do not accept money or issue the Temporary Insurance Receipt (form NB5004) if:

- Any of the questions on the Temporary Insurance Agreement Application (form NB5003) are answered "Yes" or left blank, or
- the Proposed Life insured is under age 20 or over age 70, or
- the face amount applied for is in excess of $10,000,000 (individual) or $15,000,000 (survivorship).

5. Special Instructions for Pre-Authorized Payment Plan

To avoid delays, please include a voided sample check showing banking particulars with this application.

The monthly draft will occur on the monthly processing date for the policy. If a special draft date is requested that is after the monthly processing date, we may require an additional premium to maintain guarantees.

For the following products, the draft will occur on the third Friday of each month:

- Performance Survivorship UL
- Level Premium Estate Protection

The option of drafting the initial premium is only available on the following products:

- Modified Premium Whole Life
- Level Premium Whole Life

6. 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).

7. 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.

LifeCare Benefit Rider

- Obtain the LifeCare Benefit package NB5018Kit from the website, www.jhsalesnet.com
- Complete form NB5018. Provide the Proposed Life Insured with the Notice of Replacement form NB5019, if applicable.
- Follow the specific kit instructions to ensure the correct Outline of Coverage form is given to the Proposed Life Insured.

Living Care Benefit Rider (John Hancock legacy products)

- Provide the Proposed Life Insured with the Disclosure Statement, DISC-1-LCB. This form is part of the application kit.
- Proposed Life Insured must sign the statement as the Applicant.

Accelerated Death Benefit (for terminal illness)

- Provide the Owner with the Disclosure Statement, NB1237. This form is part of the application kit.

John Hancock

Application for Life Insurance

☐ **John Hancock Life Insurance Company (U.S.A.)**
☐ **John Hancock Variable Life Insurance Company**
☐ **John Hancock Life Insurance Company**
(hereinafter referred to as The Company)

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

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Policy No. (for Internal Use Only)

Proposed Life Insured (Life One)

1. a) Name — First / Middle / Last

b) Date of Birth — mmm / dd / yyyy c) Sex ☐ M ☐ F

d) Place of Birth — State / Country

e) Citizenship ☐ U.S. ☐ Other

f) Social Security/ Tax ID Number

g) Driver's License No. — State: empty

h) Home Address — Street No. & Name, Apt No.

City / State: empty / Zip code

i) Years at this Address

j) Tel Nos. — Home / Business

k) Name of Employer

Address of Employer — Street No. & Name, Apt No.

City / State: empty / Zip code

l) Occupation

Proposed Life Insured (Life Two)

2. a) Name — First / Middle / Last

b) Date of Birth — mmm / dd / yyyy c) Sex ☐ M ☐ F

d) Place of Birth — State / Country

e) Citizenship ☐ U.S. ☐ Other

f) Social Security/ Tax ID Number

g) Driver's License No. — State: empty

h) Home Address — Street No. & Name, Apt No.

City / State: empty / Zip code

i) Years at this Address

j) Tel Nos. — Home / Business

k) Name of Employer

Address of Employer — Street No. & Name, Apt No.

City / State: empty / Zip code

l) Occupation

Owner - Complete information only if Owner is other than Proposed Life Insured.

If Trust Owner, complete questions 3. a), d) and e) and Trust Certification PS5101. Date of Trust — mmm / dd / yyyy

3. a) Name

b) Date of Birth (If individually owned) — mmm / dd / yyyy c) Relationship to Proposed Life Insured(s) d) Social Security/ Tax ID Number

e) Address — Street No. & Name, Apt No. / City / State: empty / Zip code

4. Multiple Owners - *Provide details as above for other owner(s) on a separate page.* Type of ownership ☐ Joint with right of survivorship ☐ Tenants in Common

Other Information - MUST BE COMPLETED

5. Is there, or will there be, an understanding or agreement providing for a party, other than the Owner designated in question 3. a), to obtain 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 - give details

6. a) What is the source of the funding for the policy(ies) currently applied for?

b) Will the Owner, now or in the future, be paying premiums funded by an individual and/or an entity other than the Proposed Life Insured(s), or the Proposed Life Insured's employer? ☐ Yes - If **Yes**, answer question 7. ☐ No - If **No**, proceed to question 8.

7. Will the premiums be financed through a loan?

☐ No - If **No**, describe the funding arrangement.

☐ Yes - If **Yes**, answer the following questions.

a) What is the interest rate per annum? %

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

☐ No ☐ Yes - give details

c) What is the duration of the loan?

d) Who is the lender?

e) What amount and type of collateral is required to secure the loan? Amount $ Type of Collateral

Beneficiary Information - Subject to change by Owner

8. a) Name of Primary Beneficiary — First / Middle / Last

b) Relationship to Proposed Life Insured(s)

c) Name of Secondary Beneficiary — First / Middle / Last

d) Relationship to Proposed Life Insured(s)

Coverage Applied For

9. ***Complete the applicable Policy 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.***

Juvenile Insurance - Do not complete for Children's Insurance Rider.

10. a) Are all siblings equally insured? ☐ Yes ☐ No

b) Amount of life insurance currently in force or pending on parent(s)/guardian(s) $

If none, give details.

Existing and Pending Insurance - Proposed Life Insured(s)

	Life One	Life Two
11. a) Total insurance in force on the Proposed Life Insured(s), including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity.	$	$
b) Including this application, total insurance currently pending with all companies.	$	$
c) Of the above pending amount in 11. b), how much do you intend to accept?	$	$

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

Life One: ☐ No ☐ Yes - give details

Life Two: ☐ No ☐ Yes - give details

e) Provide information for each policy in force on the Proposed Life Insured(s), including any policy that has been sold, assigned or settled to or with a settlement or viatical company or any other person or entity. (Attach additional page if necessary.)

Proposed Life Insured	Company	Insurance			Issue Date	To Remain In Force?		Face Amount
		Group	Personal	Business	mmm dd yyyy	Yes	No	
☐ One ☐ Two		☐	☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐	☐		☐	☐	$
☐ One ☐ Two		☐	☐	☐		☐	☐	$

Existing and Pending Insurance - Proposed Life Insured(s) (continued)

	Life One	Life Two
11. f) Is Disability Insurance (DI) with Provident or Long Term Care (LTC) Insurance with the Company currently being applied for?	☐ Yes ☐ No	☐ Yes ☐ No
If **Yes,** provide DI date of application	mmm dd yyyy	mmm dd yyyy
LTC date of application	mmm dd yyyy	mmm dd yyyy

Existing Insurance - Owner(s) Replacement(s) - MUST BE COMPLETED

12. 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

Complete when applying for Face Amount of $250,000 or more, or any amount of Business Insurance, or when a Proposed Life Insured is over age 70. *(Please submit copies of financial statements, estate analysis, contractual agreements, etc.)*

13.a) What is the purpose of this insurance? (e.g. estate conservation, buy-sell, keyperson) 0

b) How was the need for the Face Amount determined?

	Life One	Life Two
c) Gross annual earned income (salary, commissions, bonuses, etc.)	$	$
d) Gross annual unearned income (dividends, interest, net real estate income, etc.)	$	$
e) Household net worth (combined)	$	

f) In the last 5 years, has/have either of the Proposed Life Insured(s), or the business had any major financial problems (bankruptcy, etc.)? ☐ No ☐ Yes - give details

Business Insurance - Complete for ALL Business Insurance

	Current Year	Previous Year
14. a) Assets	$	$
b) Liabilities	$	$
c) Gross Sales	$	$
d) Net Income after taxes	$	$
e) Fair Market Value of the business	$	$

f) What percentage of the business is owned by the Proposed Life Insured(s)? %

g) Are other partners/owners/executives being insured? ☐ Yes ☐ No
If **Yes**, give details.

Smoking Questions

15. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?

Proposed Life Insured (Life One) ☐ No ☐ Yes - give details below

Product	Frequency	Current	Past	Date last used
Cigarettes	pack(s) / day	☐	☐	mmm dd yyyy
Cigars	x / day	☐	☐	
Other:	x / day	☐	☐	

Proposed Life Insured (Life Two) ☐ No ☐ Yes - give details below

Product	Frequency	Current	Past	Date last used
Cigarettes	pack(s) / day	☐	☐	mmm dd yyyy
Cigars	x / day	☐	☐	
Other:	x / day	☐	☐	

Lifestyle Questions - Please provide details in No. 21 for Yes answers. (Page 4)

16. Do you engage in regular exercise?

Proposed Life Insured (Life One) ☐ No ☐ Yes - give details below

a) What type of exercise?

b) How many times a week? c) How long? (Hours or minutes per occasion)

Proposed Life Insured (Life Two) ☐ No ☐ Yes - give details below

a) What type of exercise?

b) How many times a week? c) How long? (Hours or minutes per occasion)

	Life One	Life Two
17. Do you expect to travel outside the U.S. or Canada, or change your country of residence in the next 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
18. 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.	☐ Yes ☐ No	☐ Yes ☐ No
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.	☐ Yes ☐ No	☐ Yes ☐ No

Lifestyle Questions (continued) - Please provide details in No. 21 for Yes answers.

	Life One	Life Two
19. a) Have you committed 2 or more moving violations within the last 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
b) Have you been convicted of driving while intoxicated or while otherwise impaired?	☐ Yes ☐ No	☐ Yes ☐ No
20. In the last 10 years, have you been convicted of a criminal offense?	☐ Yes ☐ No	☐ Yes ☐ No

21.

Proposed Life Insured (Life One)

Question No.	Details for any "Yes" answers to Lifestyle Questions

Proposed Life Insured (Life Two)

Question No.	Details for any "Yes" answers to Lifestyle Questions

Doctor/Physician - MUST BE COMPLETED

Proposed Life Insured (Life One)

22. a) Date of last visit mmm dd yyyy

b) Reason for the visit

c) Diagnosis or outcome of the visit

d) Treatment/medication prescribed

e) Name of doctor/physician consulted
First Middle Last

f) Address Street No. & Name, Suite No.

City State Zip code
empty

g) Provide name and address of doctor/physician with your complete medical records if other than above.
Name First Middle Last

Address Street No. & Name, Suite No.

City State Zip code
empty

Proposed Life Insured (Life Two)

a) Date of last visit mmm dd yyyy

b) Reason for the visit

c) Diagnosis or outcome of the visit

d) Treatment/medication prescribed

e) Name of doctor/physician consulted
First Middle Last

f) Address Street No. & Name, Suite No.

City State Zip code
empty

g) Provide name and address of doctor/physician with your complete medical records if other than above.
Name First Middle Last

Address Street No. & Name, Suite No.

City State Zip code
empty

Medical Certification - Complete this section when submitting Medical Examination of another Insurer.

23. The attached examination is on the life of:

Name of Proposed Life Insured	Name of Insurance Company	Date of Examination (mmm dd yyyy)
1.		
2.		

	Life One	Life Two
a) To the best of your knowledge and belief, are the statements in the examination true as of the date this application is signed?	☐ Yes ☐ No	☐ Yes ☐ No
b) Has the person who was examined, consulted a doctor/physician or received medical or surgical advice since the date of the examination? If **Yes**, give details:	☐ Yes ☐ No	☐ Yes ☐ No

Special Requests

24.

Declarations and Authorizations

DECLARATIONS

The Proposed Life Insured(s) and Owner(s) (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 answers in this application, which include the Policy Details and any supplemental form relating to the health, aviation 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. The insurance will not be in effect if there has been a deterioration in the insurability of any proposed life insured(s) since the date of the application.

   If the Temporary Insurance Agreement (TIA) coverage is in effect and a subsequent policy is issued within 90 days of the date of the original application, the above paragraph only applies to any amount in excess of the TIA amount.

2. (b) If premiums are paid prior to delivery of the policy and the terms and conditions of the Temporary Insurance Agreement are satisfied, insurance prior to the effective date shall be provided only under the Agreement and according to its terms.
3. FRAUD WARNING. ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURER, MAKES A CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

AUTHORIZATION TO OBTAIN INFORMATION

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

1. John Hancock Life Insurance Company (U.S.A.), John Hancock Variable Life Insurance Company or John Hancock Life Insurance Company (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 symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. In turn, The Company is free 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) any medical professional designated by me/us; or (f) any person or entity entitled to receive such information by law or as I/we may further consent.
I understand that I can revoke this permission to collect information at any time, but any revocation will not affect such information that has already been collected and relied on by The Company.
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. 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, 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.

OWNER/TAXPAYER CERTIFICATION - MUST BE COMPLETED

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. **Check 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, AND**
   - ☐ **The Internal Revenue Service (IRS) has notified me that I am subject to Backup Tax Withholding, AND**
3. **I am a U.S. resident (including a U.S. resident alien).**

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.

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

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

Signature of Agent/Registered Representative (as Witness)

x

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

x

Consent for Juvenile Insurance of Parent or Guardian, if other than Owner

x

☐ Father ☐ Mother ☐ Guardian

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

x

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

Signature of Agent/Registered Representative (as Witness)

x

Signature of Owner, if other than a Proposed Life Insured
(Signing Officer please provide title or corporate seal)

x

Signature of Owner, if other than a Proposed Life Insured
(Signing Officer please provide title or corporate seal)

x

John Hancock

Agent Report

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

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

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Policy No. (for Internal Use Only)

Owner

1. Name of Owner

2. Proposed Life Insured (Life One)
Name First Middle Last

Proposed Life Insured (Life Two)
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) Is there, or will there be an understanding or agreement providing for a party, other than the Owner designated in the Application, to obtain 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 - 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 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, please complete the Important Notice.

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", form 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. Did you see each Proposed Life Insured when the application was completed? ☐ Yes ☐ No - give details

8. Agent Information *(Always complete.)*

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

Name of Broker Dealer (if applicable) 100%

Certification and Signatures - All Agents/Registered Representatives sharing commissions 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 NAIC Buyer's Guide has been given to the Owner at time of application and that no sales material other than that approved by The Company has been used.

Signature of Agent/Registered Representative Signed at City State This Day of Year

x

John Hancock

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Policy Details - Variable Life

☐ **John Hancock Life Insurance Company (U.S.A.)**
☐ **John Hancock Variable Life Insurance Company**
☐ **John Hancock Life Insurance Company**
(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(s).*

Proposed Life Insured (Life One)

Name First Middle Last

Proposed Life Insured (Life Two)

Name First Middle Last

Name(s) of Owner(s)

Plan Name

Single Life ☐ Protection VUL ☐ Accumulation VUL ☐ Corporate VUL
☐ Other

Survivorship Life ☐ Accumulation SVUL ☐ Protection SVUL
☐ Other

Amount

1. Base Face Amount (BFA) excluding any additional benefits $ (Total Face Amount is the sum of the BFA and the SFA on Page 2.)

Premiums

2. Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ List Billed
☐ Pre-Authorized Payment Plan (See Special Instructions on cover page and complete "Request for Pre-Authorized Payment Plan" - form NB5087US.)
☐ Other

Premium Notices and Correspondence

3. a) Send Premium Notices to: ☐ Owner(s) ☐ Life One ☐ Life Two ☐ Employer's Address
b) Send Correspondence to: ☐ Same as Premium Notices (as above)
☐ Other: Name & Address

Name

Street No. & Name, Apt No.

City State Zip code

empty

VARIABLE LIFE - SINGLE LIFE

4. a) Life Insurance Qualification Test

☐ 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.

b) Death Benefit Option ☐ Option 1 (BFA) ☐ Option 2 (BFA plus Policy Value)

Protection VUL

☐ Accelerated Death Benefit (for terminal illness)

☐ Disability Payment of Specified Premium:
Monthly Specified Premium Amount
$ _____

☐ Extended No Lapse Guarantee (beyond Basic Period)
☐ To Age _____ ☐ Period _____

☐ Level Supplemental Face Amount (SFA) of
$ _____ for the life of the policy

☐ LifeCare Benefit Rider (Please complete form NB5018.)
☐ LifeCare Benefit Max (LMAX) Extension Rider

☐ Other _____

Accumulation VUL

☐ Accelerated Death Benefit (for terminal illness)

☐ Cash Value Enhancement Rider

☐ Disability Payment of Specified Premium:
Monthly Specified Premium Amount
$ _____

☐ LifeCare Benefit Rider (Please complete form NB5018.)
☐ LifeCare Benefit Max (LMAX) Extension Rider

☐ Overloan Protection Rider (Only available with GPT)

☐ Return of Premium Death Benefit (with DB Option 1 only)
Increase Rate ☐ Yes _____ % ☐ No

Percentage of Premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %

☐ Supplemental Face Amount (SFA) (Check only one option below.)
☐ Level SFA of $ _____ for life of the policy
☐ Initial SFA of $ _____ with Total Face Amount increasing
by: _____ % or $ _____ per year for _____ policy years (level thereafter)

☐ Customize Level or Increasing Schedule
(List by policy year. SFA decreases cannot be scheduled at issue.
Please complete form NB5064.)

☐ Other _____

Corporate VUL

☐ Supplemental Face Amount (SFA) (Check only one option below.)
☐ Level SFA of $ _____ for life of the policy
☐ Initial SFA of $ _____ with Total Face Amount increasing
by: _____ % or $ _____ per year for _____ policy years (level thereafter)

☐ Customize Level or Increasing Schedule
(List by policy year. SFA decreases cannot be scheduled at issue. Please complete form NB5064.)

☐ Premium Cost Recovery:
☐ Initial SFA of $ _____ with Total Face Amount increasing
by Premium Cost Recovery:
☐ Recovery increase percentage _____ %
☐ Recovery increase years (level thereafter) _____

☐ Enhanced Cash Value Rider

☐ Overloan Protection Rider (Only available with GPT)

☐ Other _____

VARIABLE LIFE - SURVIVORSHIP LIFE

5. a) Life Insurance Qualification Test

☐ 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.

b) Death Benefit Option ☐ Option 1 (BFA) ☐ Option 2 (BFA plus Policy Value)

c) Additional Benefits

Accumulation SVUL

☐ Cash Value Enhancement Rider

☐ Four Year Term (EPR)

☐ Overloan Protection Rider

☐ Policy Split Option

☐ Return of Premium Death Benefit (with DB Option 1 only)
Increase Rate ☐ Yes _____ % ☐ No

Percentage of Premiums to be returned at death
(Whole numbers only. Maximum 100%) _____ %

☐ Supplemental Face Amount (SFA) (Check only one option below).

☐ Level SFA of $ _____ for life of the policy

☐ Initial SFA of $ _____ with Total Face Amount increasing

by: _____ % or $ _____ per year for _____ policy years (level thereafter)

☐ Customize Level or Increasing Schedule
(List by policy year. SFA decreases cannot be scheduled at issue.
Please complete form NB5064.)

☐ Other _____

Protection SVUL

Extended No Lapse Guarantee (beyond Basic Period)

☐ To Age _____ ☐ Period _____

☐ Four Year Term (EPR)

☐ Cash Value Enhancement Rider

☐ Level Supplemental Face Amount (SFA) of
$ _____ for the life of the policy

☐ Overloan Protection Rider

☐ Policy Split Option

☐ Other _____

Additional Information - These questions apply to the OWNER(S) of the policy. All questions must be answered.

6. a) If an additional or optional policy is being applied for in a separate application, state plan and amount.

Plan name _____ $ _____

b) Do you understand that you may need to pay premiums in addition to Planned Premium if the current policy charges or actual investment performance 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

7. Have you received a current prospectus (and any supplements) for the applicable policy? ☐ Yes ☐ No

If **Yes,** date of prospectus(es) mmm dd yyyy _____ Date of supplement(s) mmm dd yyyy _____

Date of John Hancock Trust prospectus (if applicable) mmm dd yyyy _____ Date of supplement mmm dd yyyy _____

8. With the above in mind, does the policy meet your insurance objectives and your anticipated financial needs? ☐ Yes ☐ No

Investor Suitability Statements

9. **I UNDERSTAND THAT UNDER THE APPLIED FOR POLICY:**

(A) THE AMOUNT OF THE INSURANCE BENEFITS, OR THE DURATION OF THE INSURANCE COVERAGE, OR BOTH, MAY BE VARIABLE OR FIXED.

(B) THE AMOUNT OF THE INSURANCE BENEFITS, THE DURATION OF THE INSURANCE COVERAGE, AND THE POLICY/ACCOUNT VALUE, MAY INCREASE OR DECREASE DEPENDING ON THE INVESTMENT EXPERIENCE OF THE CHOSEN INVESTMENT ACCOUNTS AND ARE NOT GUARANTEED AS TO DOLLAR AMOUNT. ILLUSTRATIONS OF BENEFITS, INCLUDING DEATH BENEFITS, POLICY/ACCOUNT VALUES AND CASH SURRENDER VALUES ARE AVAILABLE ON REQUEST.

(C) THE ENTIRE INVESTMENT COULD BE LOST BECAUSE OF THE PERFORMANCE OF THE INVESTMENT FUND AND IN THE ABSENCE OF ADDITIONAL PREMIUM PAYMENT, THE INSURANCE COVERAGE COULD LAPSE.

Telephone and/or Internet Transfer/Allocation Change Authorization

10. **I understand and agree that:**

a) Telephone and internet transfers and allocation changes will also be subject to the conditions of the policy, the administrative requirements of The Company, and the provisions of the policy's prospectus.

b) The Company may act on telephone and internet instructions from the Owner or from any such person, if the policy is jointly owned. The Company, its agents, or representatives of employees who act on its behalf, will not be subject to any claim, liability, loss, expense or cost if it acted on good faith upon telephone or internet instructions it reasonably believes to be genuine in reliance on this signed authorization. The Company will employ reasonable procedures to confirm that the instructions communicated by telephone and internet are genuine. Such procedures shall consist of confirming a valid telephone and internet authorization form is on file, requiring the registration and the use of a unique password for internet authorization and tape recording conversations and providing written confirmation thereof.

c) The Company, at its option alone and without prior or subsequent notice to the Owner(s), or any other person or representative of the Owner(s), may record all or part of any telephone conversation containing telephone transfer and/or allocation change instructions.

d) All terms of authorization are binding upon the agents, heirs and assignees of the Owner(s).

e) This Telephone and Internet Transfer/Allocation Change Authorization will be effective until such time as (a) written revocation is received by The Company's Service Office, or (b) The Company discontinues this privilege, whichever occurs first.

Please check (✓) ONLY one box:

☐ I authorize The Company to accept telephone and internet instructions from me or any co-owner.

☐ I authorize The Company to accept telephone and internet instructions from me, any co-owner or our Registered Representative. *(Registered Representatives should contact their broker/dealer for procedures regarding this authorization.)*

11. **INVESTMENT ALLOCATION OF NET PREMIUMS - Allocation must be whole numbers. Total must be 100%.**

AGGRESSIVE GROWTH PORTFOLIOS

- % Science & Technology
- % Emerging Markets Value
- % Pacific Rim
- % Health Sciences
- % Emerging Growth
- % Small Cap Growth
- % Emerging Small Company
- % Small Cap
- % Small Cap Index
- % Dynamic Growth
- % Mid Cap Stock
- % Natural Resources
- % All Cap Growth
- % Financial Services
- % International Opportunities
- % International Small Cap
- % International Equity Index B
- % Overseas Equity
- % American International
- % International Value
- % International Core

GROWTH PORTFOLIOS

- % Quantitative Mid Cap
- % Mid Cap Index
- % Mid Cap Intersection
- % Global
- % Capital Appreciation
- % American Growth
- % U.S. Global Leaders Growth
- % Quantitative All Cap
- % All Cap Core
- % Total Stock Market Index
- % Blue Chip Growth
- % U.S. Large Cap
- % Core Equity
- % Large Cap Value
- % Classic Value
- % Utilities
- % Real Estate Securities
- % Small Cap Opportunities
- % Small Cap Value
- % Small Company Value
- % Mid Value
- % Mid Cap Value
- % Value
- % All Cap Value

GROWTH & INCOME PORTFOLIOS

- % Growth & Income
- % 500 Index B
- % Fundamental Value
- % U.S. Core
- % Large Cap
- % Quantitative Value
- % American Growth - Income
- % Equity - Income
- % American Blue Chip Income & Growth
- % Income & Value
- % Managed
- % PIMCO VIT All Asset
- % Global Allocation

INCOME PORTFOLIOS

- % High Yield
- % U.S. High Yield Bond
- % Strategic Bond
- % Strategic Income
- % Global Bond
- % Investment Quality Bond
- % Total Return
- % American Bond
- % Real Return Bond
- % Total Bond Market B
- % Core Bond
- % Active Bond
- % U.S. Government Securities
- % Short Term Bond

CONSERVATIVE PORTFOLIO

- % Money Market B *

LIFESTYLE PORTFOLIOS

- % Lifestyle Aggressive *
- % Lifestyle Growth *
- % Lifestyle Balanced *
- % Lifestyle Moderate *
- % Lifestyle Conservative *

ASSET ALLOCATION MODELS *

- % Fundamental Value of America
- % Value Strategy
- % Growth Blend
- % Global Balanced
- % Blue Chip Balanced

Only one Asset Allocation Model can be selected (allocation must be 100%).

These models are only available when the ENLG Rider is elected with Protection VUL or Protection SVUL.

- % **FIXED ACCOUNT ***

NOTE: Liquidity restrictions apply when allocating funds to the Fixed Account.

OTHER PORTFOLIO

- % _____

*** These are the only investment options available when the ENLG rider is selected on Protection VUL or Protection SVUL.**

Allocation of Monthly Charges

12. Please deduct the monthly charges from the following accounts (except Mortality and Expense Risk/Asset based Risk charges).

Account No. _____ _____ % ☐ Check box and attach sheet with additional information, if necessary.

_____ _____ %

Owner(s) Signature(s)

Signed at City State This Day of Year

Signature of Witness/Registered Representative (as Witness)

x

Signature of Owner

x

Signature of Owner

x

Registered Representative Certification - All Registered Representatives sharing commissions must sign this form.

I certify that a current prospectus (and any supplement) for the policy applied for has been given to the Proposed Life Insured(s), and to the Owner(s) if other than the Proposed Life Insured(s).

Signature of Registered Representative

x

Signature of Registered Representative

x

Signature of Registered Representative

x

Signature of Registered Representative

x

Signature of Registered Representative

x

John Hancock
the future is yours

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

HIPAA Compliant Authorization for Release of Health-Related Information

☐ **John Hancock Life Insurance Company (U.S.A.)**
☐ **John Hancock Variable Life Insurance Company**
☐ **John Hancock Life Insurance Company**
(hereinafter referred to as The Company)

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

PROPOSED LIFE INSURED

1. a) Name _____
First Middle Last

b) Date of Birth ____ ____ ____
month day year

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me (protected health information) to The Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB), and any other entity or person having protected health information about me, to disclose it to The Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any of My Providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information to The Company's affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as the MIB.

This protected health information is to be used or disclosed under this Authorization so that The Company may: 1) underwrite my application for life and/or long term care insurance, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) 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 the 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.

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 benefit payments. I understand that I or any authorized representative will receive a copy of this Authorization.

SIGNATURE

Please read the above Authorization before signing this form.

Signed at City State This Day of Year

Signature of Proposed Insured/Patient or Personal Representative

X _____

Description of Personal Representative's Authority or Relationship to Patient

John Hancock

Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

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

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Proposed Life Insured (Life One)

Name First Middle Last

State of Residence empty

Date of Birth mmm dd yyyy

Notice - Life One

To determine your insurability, the Insurer has requested that you provide a sample of your blood, oral fluids or urine for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that is performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes, and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood, urine or oral fluids test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood, oral fluids or urine abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Consent

(Each Proposed Life Insured must complete a separate Consent form.)

I have read and I understand this Notice of Consent For Testing Which May Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood, oral fluids or urine sample from me, the testing of that blood, oral fluids or urine sample, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Signed at City State This Day of Year

Signature of Proposed Life Insured

X

Company Copy - Please provide the Proposed Life Insured with a copy.

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

Notice of Disclosure of Information

☐ **John Hancock Life Insurance Company (U.S.A.)**
☐ **John Hancock Variable Life Insurance Company**
☐ **John Hancock Life Insurance Company**
(hereinafter referred to as The Company)

Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Proposed Life Insured (Life One)

Name First Middle Last

Proposed Life Insured (Life Two)

Name First Middle Last

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.

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

Medical Information Bureau (MIB Inc.)

Information you provide will be treated as confidential. The Company may, however, make a brief report thereon to the Medical Information Bureau (MIB Inc.), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB Inc. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address of the Bureau's Information Office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number (617) 426-3660.

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.

If an investigative consumer report was done, we will also disclose to you 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.

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 Life Insured with a copy.