



Corporate Solutions

Employer Worksheet

This form is to be used in conjunction with either the Modified Guarantee Standard Issue (MGSI) or Modified Guarantee to Issue (MGTI) Programs for the Corporate Solutions Program.

PROGRAM HIGHLIGHTS: Refer to the Corporate Solutions Marketing Resource Guide (LTC-BUS2100) for complete details on these programs.

In order to offer these programs, the Employer must have been in business for a minimum of two years.

The term "Eligible Employee" as used below, means employees who are between the ages of 18–64, actively at-work for the Employer for 30 or more hours a week for the past six months or more, has 10 or fewer absences in the past six months, due to sickness or injury, and is a U.S. citizen or resident.

This product is not licensed for sale outside the 50 United States and the District of Columbia. Foreign locations cannot be solicited.

PART A: GENERAL EMPLOYER INFORMATION

Information provided by the employer will be treated confidentially and will not be shared for other marketing purposes.

- 1. Company name: _____
- Address: _____
- Contact person, name/title: _____ E-mail: _____
- Phone: _____ Fax: _____

PART B: EMPLOYER DEMOGRAPHICS

- 1. Type of industry: Provide specifics on what the company and its employees do: _____
- 2. Describe any hazardous activities employees are exposed to: _____
- 3. Month and Year business was established: _____
- 4. Does the Employer have multiple office locations? Yes _____ No _____
 - a) If yes, are there multiple states? Please list: _____
 - b) Will there be separate enrollment dates for each location? Yes _____ No _____

PART C: MARKETING PROGRAM BEING REQUESTED:

1. Modified Guarantee Standard Issue (MGSI):

- 100% Employer Paid Partial Employer Pay Voluntary Pay
- Number of "eligible employees" in this group _____
- If Partial Employer Pay, what portion of the premium will the Employer pay? _____ % or \$ _____
- Product: Custom Care I, II or Essential Care I, II

2. Modified Guarantee to Issue (MGTI):

- 100% Employer Paid Partial Employer Pay Voluntary Pay
- Number of "eligible employees" in this group _____
- If Partial Employer Pay, what portion of the premium will the Employer pay? _____ % or \$ _____
- Product: Custom Care I, II or Essential Care I, II

PART D: EMPLOYER CENSUS: *A case decision will not be made without a complete census.*

Please provide a complete employer census with the information required below. Please send the census electronically via e-mail. The census should be in the following format and “eligible employees” (defined on page 1) need to be separated from all other employees (those over age 64, working part time, etc.).

1. Date of birth (mm/dd/yyyy)
2. State of residence
3. Employee ID number
4. First name
5. Last name
6. Middle initial
7. Occupation/title (if available)
8. Annual salary
9. Marital/Partner status, (if available)
10. Date of hire (mm/dd/yyyy)

PART E: OTHER LTC COVERAGE:

1. Will John Hancock’s Corporate Solutions product be offered exclusively? Yes _____ No _____
a) If No, details: _____
2. Has this group been offered John Hancock’s Group LTC coverage before? Yes _____ No _____
a) If Yes, when and what coverage levels: _____
b) How many employees are currently covered under this plan? _____
3. Has this group been offered long term care from other insurers before? Yes _____ No _____
a) If yes, when and what carrier: _____
b) How many employees are currently covered under this plan? _____

PART F: EMPLOYER COMMITMENT TO ENROLLMENT:

The following Employer support will be provided. Please note that NY and TX prohibit employer involvement in administration and solicitation.

Yes ___ No ___ Allow the program to be publicized via company publications, posters, company intranet, e-mail, tent cards, or similar material and activity.

Yes ___ No ___ Allow eligible employees to attend group meetings during company time.

Yes ___ No ___ Allow eligible employees to attend individual sessions with Producer during business hours.

Yes ___ No ___ Secure a favorable introduction for Producer by officer of the company.

Yes ___ No ___ Allow employees to payroll deduct premiums. *Complete attached List Bill Form.*

Other Please describe: _____

PART G: PRODUCER MARKETING PLAN

1. The above marketing program and educational activities will commence on _____.
2. Application solicitation will start on _____, and will end on _____. *(The enrollment period cannot be more than 60 calendar days from the start date of application solicitation.)*
3. Please describe your marketing plan in detail. **Attach to worksheet.**

PART H: BENEFIT SELECTION¹

Modified Guarantee Standard Issue: Employer agrees that the following will be offered:

<input type="checkbox"/>	1 Plan: Select One of Each: Benefit Amount Home Health Care % ³ Benefit Period Elimination Period Increase Option	Benefit Amount: <input type="checkbox"/> Monthly \$ ² _____ or <input type="checkbox"/> Daily \$ _____ Benefit Period: <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years Home Health Care % ³ : <input type="checkbox"/> 100% of Nursing Home Daily Benefit (NDB) <input type="checkbox"/> 80% NDB <input type="checkbox"/> 50% NDB Elimination Period: <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days Increase Option: <input type="checkbox"/> None <input type="checkbox"/> 5% Simple <input type="checkbox"/> 5%/3% Compound <input type="checkbox"/> 5% Compound Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture						
<input type="checkbox"/>	Range of Benefits: Select Range for Each:	Benefit Amount: <input type="checkbox"/> Monthly \$ ² _____ to \$ _____ or <input type="checkbox"/> Daily \$ _____ to _____ Benefit Period: <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years Home Health Care % ³ : <input type="checkbox"/> 100% of Nursing Home Daily Benefit (NDB) <input type="checkbox"/> 80% NDB <input type="checkbox"/> 50% NDB Elimination Period: <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days Increase Option: <input type="checkbox"/> None <input type="checkbox"/> 5% Simple <input type="checkbox"/> 5%/3% Compound <input type="checkbox"/> 5% Compound Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture						
<input type="checkbox"/>	A, B and C Plans:	<table border="1"> <thead> <tr> <th>Plan A (low)</th> <th>Plan B (medium)</th> <th>Plan C (high)</th> </tr> </thead> <tbody> <tr> <td>MBA \$² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture</td> <td>MBA \$² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture</td> <td>MBA \$² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture</td> </tr> </tbody> </table>	Plan A (low)	Plan B (medium)	Plan C (high)	MBA \$ ² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture	MBA \$ ² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture	MBA \$ ² _____ or DBA \$ _____ Benefit Period: _____ Home Health Care %: _____ Elimination Period: _____ Increase Option: _____ Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture
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Modified Guarantee to Issue: Employer agrees that the following will be offered:

<input type="checkbox"/>	1 Plan: Select One of Each: Benefit Amount Home Health Care % ³ Benefit Period Elimination Period Increase Option	Benefit Amount: <input type="checkbox"/> Monthly \$ ² _____ or <input type="checkbox"/> Daily \$ _____ Benefit Period: <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years <input type="checkbox"/> 6 years <input type="checkbox"/> 10 years Home Health Care % ³ : <input type="checkbox"/> 100% of Nursing Home Daily Benefit (NDB) <input type="checkbox"/> 80% NDB <input type="checkbox"/> 50% NDB Elimination Period: <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days Increase Option: <input type="checkbox"/> None <input type="checkbox"/> 5% Simple <input type="checkbox"/> 5%/3% Compound <input type="checkbox"/> 5% Compound Optional Benefits: <input type="checkbox"/> SharedCare <input type="checkbox"/> Nonforfeiture <input type="checkbox"/> Survivorship/Waiver ² <input type="checkbox"/> Waiver of the Home Care Elimination Period ² <input type="checkbox"/> Additional Cash Benefit ² <input type="checkbox"/> Restoration of Benefits ² <input type="checkbox"/> Enhanced Return of Premium upon Death ²
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1. Benefits, options and availability vary by state. Not all optional benefit combinations may be available. Please review the state-specific application for details.

2. Not available with Essential Care I and II products.

3. Applies to Essential Care I and II products.

PART H: BENEFIT SELECTION¹ (continued)

Modified Guarantee to Issue (continued):

<input type="checkbox"/> A, B and C Plans:	Plan A (low)	Plan B (medium)	Plan C (high)
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1. Benefits, options and availability vary by state. Not all optional benefit combinations may be available. Please review the state-specific application for details.
2. Not available with Essential Care I and II products.
3. Applies to Essential Care I and II products.

PART I: BILLING INFORMATION

Please complete the attached List Bill form if payroll deduction/list bill is being requested. **(Employer paid cases must be list billed.)**

The Employer agrees to make payroll deductions as authorized by the employees, and to send the total sum of the premiums to John Hancock, upon receipt of the list bill.

PART J: PRODUCER AND AGENCY INFORMATION

1. Company/Agency name: _____ JH agency code: _____
 Producer name: _____ Producer code: _____
 Address: _____
 Producer e-mail: _____ Phone: (__) _____ Fax: (__) _____
2. Will more than one Producer be assisting with enrollment? Yes No
If Yes, provide the following information for each Producer:
 Company/Agency name: _____ JH agency code: _____
 Producer name: _____ Producer code: _____
 Address: _____
 Producer e-mail: _____ Phone: (__) _____ Fax: (__) _____
3. Is the Producer(s) and all those in the commission hierarchy licensed and appointed in all states applicable to this case? Yes No
- 3a. If No, how do you propose to solicit the business in the states where you are not licensed? _____
4. Is this your initial marketing/ sales experience with LTC insurance? Yes No

PART K: PRODUCER AND AGENCY AGREEMENT

Completing this form does not guarantee that coverage will be offered and underwriting approval of this worksheet must be obtained prior to the start of the marketing activities and application solicitation. A current copy of the Employee Census is being made available. I certify the Employee Census provided is to the best of my knowledge accurate and that employees listed as “eligible employees” on the census meet the definition on page 1 of this form.

I further understand that to qualify for the business program selected, the enrollment must meet the minimums established by John Hancock as indicated below.

If underwriting approves this worksheet and the employer chooses the Corporate Solutions Program as the coverage they want to offer to their employees, the employer will be instructed to sign off on the Corporate Solutions Approval letter before beginning enrollment.

Name: _____ Title: _____

Agent signature: _____ Date: _____

Participation Requirements Reminder: In order for this case to qualify for the marketing program selected, John Hancock requires a minimum of 15 issued policies from the eligible employee population, or 3% of the eligible employees must be issued policies, whichever is greater. *This minimum must be achieved during the initial open enrollment period.*

JOHN HANCOCK LIST BILL REQUEST FORM

Instructions: Complete this form and submit with the employer worksheet if the employer is paying the premium or offering payroll deduction to the employees. This bill is required on all employer paid cases.

New Bill List Request

Existing List Bill, Group Number _____ (check for informational changes)

Name of List Bill Group:	
Group Billing Address:	
Billing Contact:	
Phone & Fax #:	
Number of Individuals: (Minimum three policies)	Number of Individuals Applying for Insurance with John Hancock Long Term Care # _____

Billing Mode: (Select one mode)	<input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUALLY <input type="checkbox"/> ANNUALLY
	Note: All policies must have same mode of payment and list bill notices are generated on the 15th of each month.

General Agency :	
Agent/Contact:	
Address:	
Telephone and Fax #:	

Note: A list bill account number will be assigned for your group and you will be notified of your number in the group approval letter. Once a number is assigned to your group, please remember to identify all new business submitted by indicating your list bill group number on each application.

SPECIAL INSTRUCTIONS:
