Easy LTC Worksheet

This worksheet is for data entry into the Easy LTC System. Date ______________

Determine Insurability

If your client has any of the following then we suggest not continuing with this process, as we will be unable to offer coverage.

☐ Yes	☐ No	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/Cerebrovascular Accident.
☐ Yes	☐ No	Resides in, been advised to enter, or is planning to enter a nursing home, assisted care living facility or other custodial facility, or is currently receiving home health care services or attending adult day care.
☐ Yes	☐ No	Requires human assistance or supervision with any of the following activities: bathing, dressing, eating, continence, toileting, walking, transferring to or from a bed or a chair.
☐ Yes	☐ No	Is currently using any of the following medical devices: wheelchair, walker, hospital bed, quad cane, oxygen, stair lift, or dialysis.
☐ Yes	☐ No	Been diagnosed or treated by a member of the medical profession for: AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex.

For questions or concerns about the insurability of your client call our underwriting pre-qualification support line 1-888-604-7296 Option 3 and speak directly to an underwriter or complete and fax the Pre-qualification Worksheet to John Hancock.

Client Information

First: | ***MI:*** | ***Last:***

Street (No P.O. Box): | ***County*** *(if CA, NY):*

City: | ***State:*** | ***Zip:*** | ***Date of Birth:***

Sex: ☐ ***Male*** ☐ ***Female*** | ***SS#:*** | ***Birth Place:*** *(State, Country):*

Marital Status: ☐ ***Single*** ☐ ***Married-Name of Spouse*** ☐ ***Partner-Name of Partner:***

Evening Tel. #: | ***Day Tel. #:*** | ***Best time for Nation's CareLink to call:***

Primary Care Physician Name, Phone No. and address:

Internal Account #*(if applicable):* | ***Sponsored Group #****(if applicable):*

Replacement: ☐ ***Yes – Name of Carrier*** ☐ ***No*** *(If "Yes", complete a replacement form)*

Payment Information

Billing Options: *(choose only one)*
☐ ***Direct Bill***
☐ ***Monthly Bank Draft*** *(complete bank details)*
☐ ***Credit Card*** *(complete card details)*

Frequency: ☐ *Annual* ☐ *Semi-Annual* ☐ *Quarterly* ☐ *Internal Account*

Bank Details *(complete only if a monthly bank draft or Internal Account option is requested)*

Bank Name: | ***Bank Account #:*** | ***Account Type:*** ☐ ***Checking*** ☐ ***Savings***

Bank Routing #: | ***Select Draft Date*** *(1-28):* | ***Name of Depositor(s):***

Credit Card Details *(complete only if a credit card option is requested)*

Card Number: | ***Expiration Date:*** | ***Payment Frequency:*** ☐***Quarterly*** ☐ ***Monthly***

Card Type: ☐ ***Mastercard*** ☐ ***Visa*** | ***Cardholder's Name:***

Cardholder's Address:

Producer Information

First: | ***MI:*** | ***Last:***

SS#: | ***Tel. No.:*** | ***Email:***

FAX No.: | ***Wholesaler:*** ***CAPITAS/PSWF- 588***

For producer use only. This is not an application and does not bind coverage.
John Hancock Life Insurance Company, Boston, MA 02117

HIPAA Medical Authorization

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

This authorization is intended to comply with HIPAA. "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of health information about me.

1. The health information that I am authorizing to be used or disclosed consists of all the following information: *my medical records and medical history*; and other information that relates to:
   - the diagnosis of any physical or mental condition; or
   - the treatment or prognosis of any physical or mental condition,

   whether such information is in electronic or paper form. This includes, but is not limited to, information related to psychiatric or psychological conditions; prescription drugs; alcohol or drug abuse; and communicable or infectious conditions such as Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life Insurance Company (U.S.A.) (John Hancock)); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.
3. Health information about me may be disclosed to John Hancock and its affiliates; service providers; reinsurers; agents and representatives; and to any consumer reporting agency such as the MIB.
4. Health information about me may be used or disclosed: in connection with my application; to determine the premium for long term care insurance; to service my long term care insurance coverage; and to evaluate any claim for long term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization. For example, we may be obligated to disclose health information to government, regulatory and law enforcement entities.
5. John Hancock is authorized to disclose health information about me to my doctor or other individual as designated below. Please provide name, address and telephone number such individual or entity.

Name: ______________________ Phone No.: ______________

Address: ______________________________________

6. I understand that:
   - If I do not sign this Authorization, John Hancock may: decline to issue long term care insurance coverage to me; decline to pay any claim for such benefits; and decline to provide health information about me to my doctor or the individual/entity that I have designated above.
   - This authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I understand that I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
   - My health information may be re-disclosed and no longer protected by HIPAA if the person receiving my health information is not required to comply with HIPAA. HIPAA only regulates certain types of entities, such as insurers and health care providers. However, John Hancock does require its agents and service providers to protect the confidentiality of health information.
   - A copy of this Authorization is as valid as the original.
   - I will receive a copy of this authorization.
   - This Authorization expires 24 months from the date I sign it.

______________________________ ______________

Printed Name Date

____

Signature

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included: ______________________________

Long-Term Care Insurance Personal Worksheet

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

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, John Hancock Life Insurance Company (U.S.A.) must fill out part of the information on this worksheet and ask you to fill out the rest to help you and us decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Number: ☐ LTC-03 CT ☑ LTC-03 CTP ☐ LTC-06 CT

The premium for the coverage you are considering will be $____________ per ______________ (frequency).

Type of Policy: Guaranteed Renewable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS

John Hancock Life Insurance Company (U.S.A.) has a right to increase premiums on this policy form in the future, provided we raise rates for all policies in the same class in this state subject to the approval of the Connecticut Insurance Department.

RATE INCREASE HISTORY

John Hancock has sold individual long-term care insurance since 1987 and has sold these John Hancock policy form series since 2006. We have not raised rates on these policies forms in this or any other state. However, in the past ten years, we have raised rates on the following individual policy series that are no longer available for sale, as summarized below.

States	**John Hancock Policy Series***	**Years Available for Sale**	**Year of Increase/ Percentage Of Increase**
All states	LTC-91; NH-91; LTC-91-RWJ; NH-91-RWJ; LTC-94-RWJ; NH-94-RWJ; LTC-93; NH-93; LTC-94; NH-94; LTC-95; LTC-96; LTC-96 9/96; LTC-96CL; LTC-96CL 9/96; NH-99 4/99 & LTC2000 4/00	1991 – 2003	2008 – 2009: 13% maximum increase *(actual may vary by state)*
CA, CT, IN NY	LTC-96RWJ; NH-96RWJ; LTC-98RWJ; LTC-RWJ99; NH-RWJ99	1998 – 2006	2008 – 2009: 13% maximum increase *(actual may vary by state)*
States	**American Republic Policy Series* 1**	**Years Available for Sale**	**Year of Increase/ Percentage Of Increase**
AL, AZ, CO, IL, IN, IA, KS, MO, MS, NE, NV, NC, ND, OR, SC, SD, TN, WI, WY	A-3541 & A-3542	1997 – 2003	2008 – 2009: 13% maximum increase *(actual may vary by state)*
States	**Fortis Policy Series* 2**	**Years Available for Sale**	**Year of Increase/ Percentage Of Increase**
CA, FL, IL, IA, KS, KY, MO, NE, ND, OH, SD and TX.	4040, 4042 & 4043; With associated riders 2020, 2021, 2022 & 2023 (where applicable)	1993 – 1997	2003: 30% increase

* *Not every policy series was available in every state.*

1. *John Hancock administers and services these policy series for American Republic Insurance Company.*

2 *In March, 2000, John Hancock entered into an agreement whereby it would administer and reinsure the Fortis Insurance Company (now known as Time Insurance Company) and Fortis Benefits Insurance Company (now known as Union Security Insurance Company) block of individual long-term care insurance. The premium rates on the Fortis policy series shown have been increased.*

Long-Term Care Insurance Personal Worksheet *(continued)*

States	Fortis Policy Series* [2]	Years Available for Sale	Year of Increase/ Percentage Of Increase
All states (except AK, DC, HI, ID, IA, KS, MA, ME, MN, NJ, NM, NY and VT)	Policy series 4000, 4002, 4006, 4008, 4040, 4042 &/or 4043	1993 - 1997	2005: • 12% - 40% increase for series 4000, 4002, 4040, 4042, &/or 4043 except in: o LA, MI, NV & SC - increase range was 39% - 56%; o NC - increase range was 27% - 47% o VA - increase range was 88% - 110% • 27% - 47% increase for series 4006 & 4008
GA, KS, MD & WI	4040, 4042 & 4043; without associated riders 2020, 2021 (where applicable)	1993-1997	2007: • 4040 Series: 8% - 20% increase • 4042 Series: 13% - 25% increase • 4043 Series: 5% increase GA only.
All states	4060; 4061; 4062; 4063; 4060(Rev. 1-97); 4061 (Rev. 1-97); 4062 (Rev. 1-97); 4063 (Rev. 1-97); 6062; 6063; 6072 & 6073	1997 - 2003	2008 - 2009: 18% maximum increase *(actual may vary by state)*

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

❑ Yes ❑ No

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ❑ Yes ❑ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

The average annual cost of nursing home care in Connecticut in 2007 was $109,100, but this figure can vary across the country. In ten years, the average annual cost in Connecticut would be about $168,916 if costs increase 5% annually.

Long-Term Care Insurance Personal Worksheet *(continued)*

What elimination period are you considering?

Number of days: ____________

Approximate cost: $____________ for that period of care.

How are you planning to pay for your care during the elimination period? (check all boxes that apply)

❑ From My Income ❑ From My Savings/Investments ❑ My Family Will Pay

QUESTIONS RELATED TO YOUR SAVINGS AND INVESTMENTS

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your assets to change over the next 10 years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

DISCLOSURE STATEMENT

(Check one)

❑ The information provided in this worksheet accurately describes my financial situation.

or

❑ I choose not to complete the financial information in this worksheet.

❑ **◀ This box must be checked.** I acknowledge that John Hancock Life Insurance Company (U.S.A.) and/or its agent (below) have reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.**

Applicant's Signature: X____________________ Date ________

❑ I explained to the applicant the importance of completing this information.

Agent's Signature: X____________________ Date ________

Agent's Printed Name: ____________________

❑ My agent has advised me that this policy does not appear to be suitable for me. However, I still want John Hancock Life Insurance Company (U.S.A.) to consider my application.

Applicant's Signature: X____________________ Date ________

A company representative may contact you to verify your answers.

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application and information that you have furnished, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by John Hancock Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT, BROKER OR OTHER REPRESENTATIVE I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all the material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: ______________

____
Applicant's Signature

____
Signature of Agent, Broker or Other Rep.

____
Print Name of Agent, Broker or Other Rep.

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

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The above "Notice to Applicant" was delivered to me on: ______________

Applicant's Signature

Signature of Agent, Broker or Other Rep.

Print Name of Agent, Broker or Other Rep.

John Hancock Life Insurance Company (U.S.A.)
Long-Term Care
Boston, MA 02117

Replacement Questionnaire
Connecticut Partnership Long Term Care Policy

Agent Instructions –

- **This form must be completed whenever a replacement is involved with a Connecticut Partnership for Long Term Care application.**
- **This Form Must Be Submitted with the Application.**
- **A copy must be given to the Applicant**

Applicant's Name: ______________________________
Applicant's Address: ______________________________
____

Agent's Name ______________________________

Name of Company on current policy: ______________________________

Current Policy Premium: ____________ Current Mode: ____________

Replacement Policy Premium: ____________ Replacement Policy Mode: ____________

Benefit Comparison

	Current Policy	Replacement Policy
Partnership- Approved (Y or N)		
Current Facility Daily Benefit		
Current Home Care Daily Benefit		
Elimination Period		
Benefit Period		
Inflation Coverage		
Optional Benefits		

Agent Statement

Please explain why this replacement is beneficial to the applicant:

____
____
____
____

Agent Signature: ____________________ Date: ____________

Applicant Signature: ____________________ Date: ____________

LTC-CT-P-REPLR

Automatic Deduction Plan (ADP) For Insurance Premiums

Use this form to authorize withdrawals from your checking/savings account to pay your insurance premium.

Need more information? Call:

Monday through Friday 8:00 A.M. to 6:30 P.M. Eastern Time
John Hancock: 1-800-377-7311
TDD Hearing/Speech Impaired: 1-800-832-5282

Return this form to:

John Hancock Financial Services
1 John Hancock Way, Suite 1965 R-03
Boston, MA 02217-1965

Please complete sections 1 and 2.

PLEASE CHECK ONE:

☐ New Policy ☐ Add ADP to an Existing Policy ☐ Change Bank Information on an Existing Policy ☐ Payment for Protested Draft (Validation)

1. Policy or Contract Information

Insured's Name: ______________________
First Middle Last

Owner's Name: ______________________
First Middle Last

Owner's Address: ______________________
City State Zip

Policy/Contract Number(s): ______________________

Daytime Phone: ____________ Evening Phone: ____________

2. Banking Information (Please attach your voided check or savings deposit slip to this form.)

Name of Bank: ____________ Bank Account Owner: ____________

Account Type: ____________ Desired Draft Day (Month/Day)(Day must = 1-28): ____________

Bank Routing Number: ____________ Account Number (Checking/Savings): ____________

I authorize John Hancock Life Insurance Company and affiliated companies to deduct the necessary premiums from the account listed above, to pay for the policies listed above. I understand the deduction will occur on the date I have selected in Section 2. If no date is selected the draft will occur on the policy issue day. I need to notify John Hancock and affiliated companies of any change to my bank account information two weeks prior to the date that the change is effective.

______________________ ______________________
Bank Account Owner Signature Date

Long-term care insurance is underwritten by John Hancock Life Insurance Company (U.S.A.), Boston, MA 02117 and in New York by John Hancock Life & Health Insurance Company, Boston, MA 02117.

LTC-7269R 3/01
Rev. 1/10

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