Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

PART II Medical Supplement

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

This form is part of the Application for Individual Life Insurance.

If a Survivorship policy is applied for, a separate Part II Medical Supplement form will need to be completed by each Proposed Insured.

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

The information you provide in this application is critical to our consideration of your request for insurance coverage. You are strongly urged to answer all questions completely and accurately so that we may provide you with the best coverage we can. We will seek information from other sources to assist us with evaluating your application, potentially including your health care provider. If your answers are incorrect, incomplete or untrue, it will delay your application, and The Company may have the right to deny benefits or terminate coverage. Please know that your personal information, including health information, is protected by The Company and only used by The Company to do business with you, and as permitted or required by law.

SECTION A: General Information

Any information that requires more space or further detail can be added in *SECTION G: ADDITIONAL INFORMATION*

1. Name FIRST MIDDLE LAST

2. Date of Birth	3. Social Security Number	4. Sex
MONTH DAY YEAR		☐ Male ☐ Female

5. Family History: *Please provide the following details concerning your biological family history to the best of your knowledge.*

FAMILY MEMBER	• Indicate any diagnosis and age of onset, if any of your immediate family members have ever been diagnosed by a member of the medical profession with Cancer, Coronary Artery Disease, Stroke, Diabetes, Huntington's, Alzheimer's, or Polycystic Kidney Disease. • Provide health status/medical condition if living.	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS/SISTERS ☐ No siblings				

SECTION A: General Information (continued)

! Only complete questions 6, 7, 8, and 9 if the Proposed Insured is age 60 or UNDER.

6. a. Provide your height: _____ feet _____ inches | b. Provide your weight: _____ pounds

7. a. Have you had any weight loss of 10 lbs. or more in the past 12 months?
☐ Yes – specify lbs.: _____ ☐ No

b. In the past 12 months have you tried to lose weight through diet or exercise?
☐ Yes ☐ No

c. Have you had any weight gain of 10 lbs. or more in the past 12 months?
☐ Yes – specify lbs.: _____ ☐ No

8. What was your last blood pressure reading? _____ / _____ ☐ Unknown

9. What was your last cholesterol reading? Total Cholesterol: _____ HDL: _____ ☐ Unknown

SECTION B: Medications

If you need more space for information, please continue to *SECTION G: ADDITIONAL INFORMATION*

10. List all medications you have taken or been prescribed in the last 12 months and the conditions for which they are being taken.

PRESCRIPTION NAME	CONDITIONS FOR WHICH THIS MEDICATION IS TAKEN

☐ I have not been prescribed any medications in the last 12 months

SECTION C: Medical Conditions

Any information that requires more space or further detail can be added in *SECTION F: ADDITIONAL MEDICAL CONDITIONS DETAILS*

11. In the last 5 years, have you been diagnosed, treated or consulted with a member of the medical profession for any of the following medical conditions?

Check all that apply and provide complete details.

MEDICAL CONDITIONS

a. ☐ High Blood Pressure
☐ High Cholesterol
☐ Coronary Artery Disease
☐ Heart Attack
☐ Cardiac Chest Pains
☐ Arrhythmia/Irregular Heart Beat
☐ Heart Murmur/Valvular Heart Disease
☐ Heart Failure
☐ Peripheral Vascular Disease
☐ Stroke/Transient Ischemic Attack (TIA)
☐ Other Disorders of the Heart or Blood Vessels
☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: _____

CONDITION NAME/DIAGNOSIS

DATE OF ONSET
MONTH YEAR

TREATMENT GIVEN

DURATION OF CONDITION

PHYSICIAN NAME ADDRESS PHONE NUMBER

HOSPITAL NAME ADDRESS PHONE NUMBER

QUESTION 11 *continues on next page*

SECTION C: Medical Conditions (continued)

MEDICAL CONDITIONS

b. ☐ Diabetes
- ☐ High Blood Sugar/Glucose Intolerance/Pre-Diabetes
- ☐ Disorders of the Thyroid or Other Glands
- ☐ None of these apply to me

c. ☐ Cancer
- ☐ Leukemia/Lymphoma
- ☐ Benign Tumor/Polyp
- ☐ Malignant Tumor/Polyp
- ☐ Malignant Melanoma
- ☐ None of these apply to me

d. ☐ Anemia/Blood Disorder
- ☐ Autoimmune Disorder
- ☐ None of these apply to me

e. ☐ Asthma
- ☐ Emphysema/COPD/Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Other Respiratory/Lung Disorders
- ☐ None of these apply to me

f. ☐ Seizures/Epilepsy
- ☐ Tremors
- ☐ Paralysis
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Cognitive Impairment/Memory Loss
- ☐ Alzheimer's Disease/Dementia
- ☐ Other Nervous System or Neurological Disorders
- ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: ______

CONDITION NAME/DIAGNOSIS		DATE OF ONSET (MONTH / YEAR)
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ______

CONDITION NAME/DIAGNOSIS		DATE OF ONSET (MONTH / YEAR)
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ______

CONDITION NAME/DIAGNOSIS		DATE OF ONSET (MONTH / YEAR)
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION 11 *continues on next page*

SECTION C: Medical Conditions (continued)

MEDICAL CONDITIONS

g. ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Other Psychological or Mental Health Disorders
- ☐ None of these apply to me

h. ☐ Ulcers
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Crohn's/Ulcerative Colitis
- ☐ Barrett's Esophagus
- ☐ Other Disorders of the Liver, Gallbladder, Esophagus, Pancreas, Stomach, or Intestines
- ☐ None of these apply to me

i. ☐ Rheumatoid/Psoriatic Arthritis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Amputation
- ☐ Other Bone, Joint, Muscle, or Connective Tissue Disorders
- ☐ None of these apply to me

j. ☐ Kidney Disease
- ☐ Disorders of the Bladder or Urinary Tract
- ☐ Disorders of the Prostate
- ☐ Disorders of the Breast
- ☐ Disorders of the Reproductive Organs
- ☐ None of these apply to me

COMPLETE DETAILS FOR ANY SELECTED MEDICAL CONDITIONS

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER: ____________

CONDITION NAME/DIAGNOSIS		DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

SECTION D: Medical Conditions and Diagnostic Tests

- For questions 12, 13, and 14, you do not need to tell us about: muscle strains, sprains, limb fractures that you have fully recovered from, normal childbirth, colds, flu, appendicitis, seasonal asthma, vasectomy, tonsillitis, conjunctivitis, or hay fever
- Provide complete details to any 'yes' responses
- If you need more space for information, please continue to *SECTION G: ADDITIONAL INFORMATION*

12. Completed Diagnostic Testing: Within the past 2 years have you undergone any diagnostic tests (e.g. Blood, urine, EKGs, X-rays, screening tests for family history) excluding HIV, whether conducted on an inpatient or out-patient basis?

☐ Yes ☐ No

If Yes, give details _____

13. Pending Tests or Procedures: In the past 2 years have you been advised by a member of the medical profession to have any surgery, procedure, treatment or diagnostic testing (including any screening tests for family history, but excluding those for HIV), other than for routine screening purposes that have not yet been completed or results which have not yet been received?

☐ Yes ☐ No

If Yes, give details _____

14. Other than what has already been asked, within the last 5 years have you been treated, consulted, or given medical advice by a member of the medical profession in any hospital, emergency room, urgent care or medical facility for any disease, disorder, symptoms, or injury not previously mentioned?

☐ Yes ☐ No

If Yes, give details _____

15. Have you been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?

☐ Yes ☐ No

If Yes, give details _____

SECTION E: Personal Information

16. Describe your present alcohol consumption.

Note: Alcohol types and equivalent amounts: 1 Beer = 12 oz. 1 Wine = 4 oz. 1 Liquor = 1 oz.

If consumption exceeds the allotted space below, list remainder in SECTION G: ADDITIONAL INFORMATION

TYPE OF BEVERAGE	AMOUNT (# OF DRINKS) AND FREQUENCY	DATE LAST USED (MONTH/YEAR)
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR
	Amount _____ per ☐ Day ☐ Week ☐ Month ☐ Year	MONTH YEAR

☐ I have not consumed alcohol in the past 10 years

17. In the past 10 years have you been advised to limit or discontinue alcohol use, or sought or received counseling or treatment by a member of the medical profession for alcohol use?	☐ Yes ☐ No
18. Within the last 10 years have you used, or tested positive by a member of the medical profession for:	
a. Cocaine, heroin, amphetamines, or hallucinogens?	☐ Yes ☐ No
b. Tranquilizers, sedatives or narcotic drugs or any prescription drug except those used in accordance with physician's instructions?	☐ Yes ☐ No
19. In the past 10 years have you sought or received treatment by a medical professional, counseling or participated in a support group for drug use?	☐ Yes ☐ No

If YES to questions 17, 18 or 19 please provide details:

SECTION F: Additional Medical Conditions Details

This is additional space if required for conditions identified in question 11 A - J

QUESTION NUMBER	CONDITION NAME/DIAGNOSIS	DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

QUESTION NUMBER	CONDITION NAME/DIAGNOSIS	DATE OF ONSET MONTH YEAR
TREATMENT GIVEN		DURATION OF CONDITION
PHYSICIAN NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

SECTION G: Additional Information

This is additional space if required for any of the previous questions

QUESTION NUMBER	DETAILS

Read previous pages carefully and sign below

I, THE PROPOSED INSURED, AUTHORIZE:

1. The Company to obtain consumer reports including but not limited to motor vehicle records and investigative consumer reports on me.

2. Any medical professional, medical care provider, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, electronic health record provider, insurance company, the MIB, Inc. ("MIB") or any other similar person or organization to disclose health information about me or any minor child who is to be insured. Health information includes: (i) my entire medical record and medical history, prescription history, and other health information; (ii) confidential information related to Human Immunodeficiency Virus (HIV), other communicable diseases and mental illness (excluding psychotherapy notes) and (iii) genetic information and genetic test results, to the extent permitted by law.

3. Any financial professional, CPA, attorney, personal banker or any other similar person or organization to disclose financial/ net worth information about me.

Such disclosure of my information may be made to The Company, its affiliated companies, agents, service providers, reinsurers, MIB or any person or entity entitled to receive such information by law or as I may further consent.

Information collected under this authorization will be used to evaluate my application for insurance, identify any misrepresentation in the information provided by me in this application, administer coverage, evaluate a claim for benefits, for reinsurance or other insurance purposes, or to conduct other legally permissible activities. I authorize The Company, or its reinsurers, to make a brief report of my health information to MIB.

This authorization is valid for 24 months from the date shown below or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery, whichever period is shorter. A photocopy of this authorization will be as valid as the original. I am entitled, or my authorized representative is entitled, to a copy of this authorization.

I understand that I can revoke this permission to collect information at any time by providing written notification to John Hancock Life Insurance Company (U.S.A.) at the Service Office address (page 1) Attention: Chief Underwriter, but any revocation will not affect such information that has already been collected and relied on by The Company.

SIGNATURES

I have read the statements and answers on this Part II Medical Supplement, and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for which this information was required by The Company.

SIGNED AT CITY STATE THIS DAY OF YEAR

X _____

SIGNATURE OF PROPOSED INSURED (PARENT OR GUARDIAN IF UNDER AGE 15)

X _____

SIGNATURE OF EXAMINER (IF APPLICABLE)

Service Office:
Life New Business
30 Dan Rd, Suite 55765
Canton, MA 02021-2809

Examiner's Report

JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.)
(hereinafter referred to as The Company)

Print and use black ink.

SECTION A: Proposed Insured

1. a. Name FIRST MIDDLE LAST

b. Date of Birth MONTH DAY YEAR

SECTION B: Medical Observations

2. a. Height _____
   Did you measure? ☐ Yes ☐ No
   b. Weight _____
   Did you weigh? ☐ Yes ☐ No
   c. Any weight change in the past 12 months? ☐ Yes ☐ No
   If Yes, amount _____ ☐ Loss ☐ Gain
   Reason _____

3. Blood Pressure Readings

	1.	2.	3.
Systolic			
Diastolic			

4. Pulse _____ ☐ Regular ☐ Irregular
   Type of irregularity _____
   If extra systoles, No. per min. _____

5. Describe general appearance _____

6. Did anyone accompany the Proposed Insured during the examination? ☐ Yes ☐ No
   If Yes, please provide details
   Name of the person who came _____ Relationship to Proposed Insured _____
   Why present _____

7. Did the Proposed Insured understand and answer all the questions asked in connection with this exam? ☐ Yes ☐ No
   If No, please provide details _____

8. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes, or drugs? ☐ Yes ☐ No
   If Yes, please provide details _____

9. Additional observations/comments (if applicable)

SECTION D: Examiner's Certification and Signature

How did you identify the Proposed Insured? ☐ Driver's License (with photo) ☐ Other photo ID _____

Examination location ☐ Examiner's Office ☐ Proposed Insured's home ☐ Proposed Insured's place of business

Indicate requirements completed ☐ Blood ☐ Urine ☐ EKG ☐ TST

Ticket number _____ Date sent to lab MONTH DAY YEAR Date sent to home office MONTH DAY YEAR

Indicate any requirements not completed and reason

I hereby certify that I have personally examined the Proposed Insured and have correctly and fully reported my findings.

SIGNED AT CITY STATE THIS DAY OF YEAR

☐ MD ☐ RN
☐ DO ☐ RPN/LPN

NAME OF EXAMINER

X _____
SIGNATURE OF EXAMINER

Company
☐ APPS ☐ EMSI ☐ Exam One ☐ Portamedic
☐ Superior Mobile Medics ☐ Other _____
City/State Telephone No.

Examination completed on (date and time)
MONTH DAY YEAR
Time