Value Enhancement rider/ CAREAdvantage℠ benefit authorization

Before you begin

Use this form to initiate a request for benefits under the Value Enhancement rider (also known as CAREAdvantage℠). Please note:

- The deferral period must have elapsed in order to be eligible to submit a request for benefits. Consult your annuity contract/certificate (contract) and/or prospectus for the specific length of the deferral period.
- This request is subject to verification of eligibility.
- Should your request be approved, any monthly benefits received will be credited to your contract.

If you wish to withdraw benefit amounts, you must submit a withdrawal request by completing the Withdrawal request form (either 130711 or 130701). The withdrawal of benefit amounts is subject to the same tax treatment as other contract withdrawals.

Important information

The Value Enhancement rider is designed to supplement your annuity to help with unexpected costs such as nursing home or home healthcare expenses. Please note that this benefit is not a reimbursement for medical expenses, but rather an additional credit to your contract to use at your discretion.

In order to be eligible to receive benefits, you must satisfactorily complete the review process to verify your eligibility. This process consists of three steps: confirmation of benefit eligibility, confirmation of provider eligibility, and fulfillment of a 100-day elimination period. Each of these steps, further explained below, must be satisfied before benefit payments can begin.

- **Step 1: Benefit eligibility**—John Hancock must determine that the covered person's medical needs meet the contract's benefit eligibility requirements. Once we receive this form, a benefit coordinator will call to assess the covered person's condition and confirm the care services the covered person is currently receiving. John Hancock will determine benefit eligibility based on this assessment, and you will be notified of the decision in writing.
- **Step 2: Provider eligibility**—Your John Hancock contract requires that the care assistance services the covered person receives be provided by a recognized and qualified care provider. Once we review, we will notify you in writing if the care provider meets your contract requirements.
- **Step 3: Fulfillment of elimination period**—Satisfying the elimination period is the last step required before receiving benefits. Your John Hancock contract requires that the covered person receive 100 days of paid care services before benefit payments can begin. In order to substantiate that the covered person is receiving these services, you will be asked to submit the care provider's bills or statements, indicating the dates when services were provided. You will be notified in writing with instructions on how to submit information to fulfill the elimination period, as well as what services are eligible.

If you or the covered person have a designated representative to handle legal affairs, such as under a power of attorney, a copy of the authorization must be submitted with this form. If you have any questions about this form or your contract, please call us at 800-344-1029.

Contact information

Website:
johnhancock.com/annuities

Phone: 800-344-1029
TTY: 800-555-1158

Mail:
See return instructions at end of this form.

Issuer: John Hancock Life Insurance Company (U.S.A.), Lansing, MI (not licensed in New York). **Issuer in New York:** John Hancock Life Insurance Company of New York, Valhalla, NY.
1307203 (8/23)

1. Contract information

Contract number

Owner information:

Owner name (or custodian name, if applicable) (First) | MI | Last | Date of birth (mm/dd/yyyy)

Social Security number (or TIN) | Phone number | Email address

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

☐ Check here if address provided is permanent address change for your annuity contracts.

Financial professional name (if applicable) (First) | MI | Last | Phone number

Co-owner information (if applicable):

Co-owner name (First) | MI | Last | Date of birth (mm/dd/yyyy)

Social Security number (or TIN) | Phone number | Email address

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Covered person information (if different from owner):

Covered person name (First) | MI | Last | Date of birth (mm/dd/yyyy)

Social Security number (or TIN) | Phone number | Email address

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

2. Benefit authorization

☐ **By checking this box,** I confirm I wish to begin receiving benefits under the Value Enhancement rider. To the best of my knowledge, the covered person meets all benefit eligibility requirements described in my contract.

3. Benefit delegates (optional)

During this benefit request process, it may be easier for you to assign a delegate, such as an immediate family member, to facilitate the benefit request on your behalf. The individuals listed below are authorized to receive information regarding your request for Value Enhancement rider benefits. By providing their information, you understand that they are authorized to receive information pertaining only to the Value Enhancement rider benefit request. The individuals listed below are not authorized to receive other contract information unrelated to the benefit request or initiate any financial transaction on your behalf. Any power of attorney on file supersedes this statement.

John Hancock is authorized to disclose health information about you to the individuals designated below:

1. Name (First) | MI | Last | Date of birth (mm/dd/yyyy)* | Phone number

2. Name (First) | MI | Last | Date of birth (mm/dd/yyyy)* | Phone number

* For security verification purposes.

Contract number: _____

4. Signatures and authorizations

By signing below, I hereby certify the information on this form is complete and accurate. I understand that this request is subject to all the terms and conditions of the contract.

Any person who, knowingly and with the intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and is subject to criminal prosecution and/or civil penalties.

Certification required of U.S. persons only (including U.S. citizens, U.S. resident aliens, or other U.S. persons).

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number,
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup 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 withholding, and
3. I am a U.S. citizen or other U.S. person, including a U.S. resident alien (as defined in the IRS Form W-9 instructions).

Certification instructions: You must check the box below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to prevent backup withholding.

SIGN HERE

_____ _____

Signature of owner (or fiduciary) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

SIGN HERE

_____ _____

Signature of co-owner (or fiduciary) (if applicable) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

SIGN HERE

_____ _____

Signature of covered person (or fiduciary) (if different from owner) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable):

☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other _____

Return instructions

Please submit your completed and signed form via one of the following:

National contracts:
John Hancock Annuities Service Center
PO Box 55444
Boston, MA 02205-5444

New York contracts:
John Hancock Annuities Service Center
PO Box 55445
Boston, MA 02205-5445

All overnight mail:
Annuities Service Center
John Hancock Insurance
410 University Avenue, Suite 55444
Westwood, MA 02090

Register online:

Go to **johnhancock.com/annuities** to create an online account and gain access to contract-specific details and self-service tools. Once registered, select to receive your contract documents electronically under your Paperless settings.

Claim initiation

Important information

Completion of this form may be necessary to begin the John Hancock long-term care (LTC) claim process. Please note you are required to provide accurate and complete information to the best of your knowledge and ability. Any failure to do so could jeopardize the claim. **Form completion does not guarantee claim approval and/or benefit payment.**

Contact information

Website:
johnhancock.com/annuities

Phone: 800-344-1029
TTY: 800-555-1158

Mail:
See return instructions at end of this form.

1. Covered person information

Contract number

Covered person name (First) | MI | Last | Married: ☐ Yes ☐ No

Social Security number (or TIN) | Date of birth (mm/dd/yyyy)

Phone number | Email address

Current status:

☐ Receiving services/needs assistance
☐ Recovered, received services prior to recovery
☐ Deceased, received services prior to death

Primary residence:

Facility name (if applicable) | Preferred contact phone number

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Current location: (if different from primary residence)

Facility name (if applicable) | Preferred contact phone number

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Contract number: _____

1. Covered person information (continued)

Primary contact for this claim:

☐ **Covered person:** (select one below)

- ☐ Send correspondence to primary residence
- ☐ Send correspondence to current location

☐ **Other:** (complete contact information below, and if attorney-in-fact or guardian, attach documentation)

Primary contact name (First) _____ MI _____ Last _____

Relationship to covered person _____ Phone number _____ Email address _____

Address (Street) _____

City _____ State _____ Zip code _____ Country (if outside the U.S.) _____

2. Claim information

Brief explanation of why this claim is being opened:

☐ Yes ☐ No Is this claim being opened because the covered person needs assistance with any of the following activities: bathing, dressing, eating, toileting, maintaining continence, mobility, or transferring from bed to chair?

If **yes**, the approximate date the assistance began: _____ mm/dd/yyyy

☐ Yes ☐ No Is this claim being opened because the covered person needs supervision due to memory or cognitive issues resulting from a diagnosis such as Alzheimer's or dementia?

If **yes**, the approximate date the assistance began: _____ mm/dd/yyyy

☐ Yes ☐ No Is this claim related to more than one John Hancock policy that covers long-term care services?
If **yes**, please list all policy numbers (for group/employer-sponsored plans, list the employer name):

☐ Yes ☐ No Has anyone else in the household or family (e.g., spouse) filed a John Hancock LTC claim or is currently on claim?
If **yes**, please list all claim numbers and names:

Is this claim being opened as a result of any of the following?

☐ Yes ☐ No Motor vehicle accident-related injury

☐ Yes ☐ No Work-related injury

☐ Yes ☐ No Hospice services
(If **yes**, provide detail in enclosed Medical and long-term care service provider information form)

If currently in a skilled nursing facility, provide the expected discharge date/time frame (if known):

Contract number: _____

3. Signature and authorization

By signing below, I hereby certify that the information provided on this form is accurate and complete to the best of my knowledge and ability.

Any person who, with an intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. Please refer to the enclosed State fraud warnings for state-specific wording regarding the above fraud statement.

Certification required of U.S. persons only (including U.S. citizens, U.S. resident aliens, or other U.S. persons).

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number,
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup 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 withholding, and
3. I am a U.S. citizen or other U.S. person, including a U.S. resident alien (as defined in the IRS Form W-9 instructions).

Certification instructions: You must check the box below if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

☐ I am subject to backup withholding as a result of a failure to report all interest and dividends.

If you are signing on behalf of another individual (e.g., Power of Attorney, Guardian), please indicate your title by checking the appropriate box below your signature. In order to accept a signature other than the covered person's on this form, please submit the applicable documentation (such as a power of attorney).

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to prevent backup withholding.

SIGN HERE _____ _____

Signature of covered person (or fiduciary) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable): ☐ Power of Attorney ☐ Guardian ☐ Other: _____

Return instructions

Please mail your completed and signed Claim initiation form, Medical and long-term care service provider information form, and HIPAA compliant authorization to the address below:

National contracts:
John Hancock Annuities Service Center
PO Box 55444
Boston, MA 02205-5444

New York contracts:
John Hancock Annuities Service Center
PO Box 55445
Boston, MA 02205-5445

All overnight mail:
Annuities Service Center
John Hancock Insurance
410 University Avenue, Suite 55444
Westwood, MA 02090

Medical and long-term care service provider information

Important information

Completion of this form may be necessary to begin the John Hancock long-term care (LTC) claim process. Please note you are required to provide accurate and complete information to the best of your knowledge and ability. Any failure to do so could jeopardize the claim. **Form completion does not guarantee claim approval and/or benefit payment.**

1. Covered person information

Contract number

Covered person name (First) | MI | Last

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

2. Medical service provider information

Physician information:

1.
Name (First) | MI | Last

Phone number | Fax number

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Date care started (mm/dd/yyyy) | Date care ended (mm/dd/yyyy)

Specialty:
- ☐ Primary care
- ☐ Cardiologist
- ☐ Neurologist
- ☐ Oncologist
- ☐ Orthopedist
- ☐ Psychiatrist
- ☐ Other _____

2.
Name (First) | MI | Last

Phone number | Fax number

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Date care started (mm/dd/yyyy) | Date care ended (mm/dd/yyyy)

Specialty:
- ☐ Primary care
- ☐ Cardiologist
- ☐ Neurologist
- ☐ Oncologist
- ☐ Orthopedist
- ☐ Psychiatrist
- ☐ Other _____

3.
Name (First) | MI | Last

Phone number | Fax number

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

Date care started (mm/dd/yyyy) | Date care ended (mm/dd/yyyy)

Specialty:
- ☐ Primary care
- ☐ Cardiologist
- ☐ Neurologist
- ☐ Oncologist
- ☐ Orthopedist
- ☐ Psychiatrist
- ☐ Other _____

Contract number: _____

2. Medical service provider information (continued)

Hospital information:

1. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

2. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

3. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

Long-term care provider information:

1. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Adult day care
- ☐ Assisted living/memory care facility
- ☐ Board and care home
- ☐ Home care agency
- ☐ Hospice facility
- ☐ Independent care provider
- ☐ Nursing home

Contract number: _____

2. Medical service provider information (continued)

Long-term care provider information:

2. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Adult day care
- ☐ Assisted living/memory care facility
- ☐ Board and care home
- ☐ Home care agency
- ☐ Hospice facility
- ☐ Independent care provider
- ☐ Nursing home

3. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Adult day care
- ☐ Assisted living/memory care facility
- ☐ Board and care home
- ☐ Home care agency
- ☐ Hospice facility
- ☐ Independent care provider
- ☐ Nursing home

4. _____
Name

_____ _____
Phone number Fax number

_____
Address (Street)

_____ _____ _____ _____
City State Zip code Country (if outside the U.S.)

_____ _____
Date care started (mm/dd/yyyy) Date care ended (mm/dd/yyyy)

Type:
- ☐ Adult day care
- ☐ Assisted living/memory care facility
- ☐ Board and care home
- ☐ Home care agency
- ☐ Hospice facility
- ☐ Independent care provider
- ☐ Nursing home

John Hancock

RETURN THIS COPY TO JOHN HANCOCK

HIPAA compliant authorization

Important information

Complete and return this copy of the authorization form to John Hancock:

- This copy includes pages 1 and 2.
- Keep the copy found on pages 3 and 4 for your records.

This authorization is intended to comply with HIPAA. HIPAA stands for Health Insurance Portability and Accountability Act of 1996 as amended. It provides your doctors and care providers with authorization to release to us medical information that pertains to your request.

1. Covered person information

Contract number

Covered person name (First) | MI | Last | Date of birth (mm/dd/yyyy)

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

2. Authorization

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

- 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 AIDS or sexually transmitted diseases.
- The following persons or entities are authorized to disclose health information about me: a doctor or medical practitioner; hospital, clinic or medical/medically-related facility; pharmacy or pharmacy benefit manager; any insurance or reinsurance company (including John Hancock Life Insurance Company (U.S.A.) (John Hancock)); any consumer reporting agency such as the MIB, Inc. (MIB) or any other organization, institution or person having health information about me.
- 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.
- Health information about me may be used or disclosed to evaluate or process any 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, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.
- John Hancock is authorized to disclose health information about me to the individuals designated below (you should consider listing your spouse, partner, children and/or any other family member or friend with whom you may want John Hancock to discuss your claim).

1. Name (First) | MI | Last | Phone number

2. Name (First) | MI | Last | Phone number

3. Name (First) | MI | Last | Phone number

4. Name (First) | MI | Last | Phone number

Contract number: _____

2. Authorization (continued)

I understand that:

- If I do not sign this authorization, John Hancock may decline my benefit or waiver request.
- Although an authorization may generally be revoked by sending a written request to John Hancock, there is no right to revoke this authorization if my claim for benefits may be contested by John Hancock or if John Hancock has already relied and acted upon this authorization.
- 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 when coverage under the annuity terminates (exception for California residents: this authorization is valid for the duration of the claim for benefits).

3. Signature

Any person who, with an intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to criminal and civil penalties. By signing below, you agree under penalties of perjury that the information in this statement is complete and true to the best of your knowledge. **Please refer to the enclosed State fraud warnings for state-specific wording regarding the above fraud statement.**

If this authorization is signed by an attorney-in-fact or guardian for the covered person, a copy of the power of attorney or guardianship document must be included.

SIGN HERE _____ _____

Signature of covered person (or fiduciary) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable): ☐ Power of Attorney ☐ Guardian ☐ Other: _____

Return instructions

Please submit your completed and signed form via one of the following:

National contracts:
John Hancock Annuities Service Center
PO Box 55444
Boston, MA 02205-5444

New York contracts:
John Hancock Annuities Service Center
PO Box 55445
Boston, MA 02205-5445

All overnight mail:
Annuities Service Center
John Hancock Insurance
410 University Avenue, Suite 55444
Westwood, MA 02090

John Hancock

KEEP THIS COPY FOR YOUR RECORDS

HIPAA compliant authorization

Important information

Complete and keep this copy of the authorization form (pages 3 and 4) for your records. It does not need to be returned to John Hancock.

This authorization is intended to comply with HIPAA. HIPAA stands for Health Insurance Portability and Accountability Act of 1996 as amended. It provides your doctors and care providers with authorization to release to us medical information that pertains to your request.

1. Covered person information

Contract number

Covered person name (First) | MI | Last | Date of birth (mm/dd/yyyy)

Address (Street)

City | State | Zip code | Country (if outside the U.S.)

2. Authorization

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

- 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 AIDS or sexually transmitted diseases.
- The following persons or entities are authorized to disclose health information about me: a doctor or medical practitioner; hospital, clinic or medical/medically-related facility; pharmacy or pharmacy benefit manager; any insurance or reinsurance company (including John Hancock Life Insurance Company (U.S.A.) (John Hancock)); any consumer reporting agency such as the MIB, Inc. (MIB) or any other organization, institution or person having health information about me.
- 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.
- Health information about me may be used or disclosed to evaluate or process any 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, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.
- John Hancock is authorized to disclose health information about me to the individuals designated below (you should consider listing your spouse, partner, children and/or any other family member or friend with whom you may want John Hancock to discuss your claim).

1. Name (First) | MI | Last | Phone number

2. Name (First) | MI | Last | Phone number

3. Name (First) | MI | Last | Phone number

4. Name (First) | MI | Last | Phone number

Contract number: _____

2. Authorization (continued)

I understand that:

- If I do not sign this authorization, John Hancock may decline my benefit or waiver request.
- Although an authorization may generally be revoked by sending a written request to John Hancock, there is no right to revoke this authorization if my claim for benefits may be contested by John Hancock or if John Hancock has already relied and acted upon this authorization.
- 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 when coverage under the annuity terminates (exception for California residents: this authorization is valid for the duration of the claim for benefits).

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If this authorization is signed by an attorney-in-fact or guardian for the covered person, a copy of the power of attorney or guardianship document must be included.

SIGN HERE

_____ _____

Signature of covered person (or fiduciary) Date signed (mm/dd/yyyy)

Title (check appropriate box, if applicable): ☐ Power of Attorney ☐ Guardian ☐ Other: _____