Withdrawal charge waiver request

Due to nursing home confinement

Important information

Use this form and enclosed HIPAA compliant authorization in conjunction with the applicable withdrawal form to request to waive a withdrawal charge due to nursing home confinement for your annuity contract with a Waiver of Withdrawal Charge rider benefit.

Refer to the following product eligibility guidelines:

Product	Account prefix	Availability by contract issue state	Maximum issue age	Other information
Allegiance Preferred	SD3	N/A in NY or NJ	74	Issue dates after 12/1/97 only
Declaration	1776	N/A in NY	74	Rider must have been elected at issue
GPA Choice	GP01, GP06, GP07, GP08, GP09, GP10, GP11, GP16	N/A in CT or OR	79	Included contract feature
GPA Choice 2003	GP15, GP20, GP24, GP26, GP54, GP70	N/A in CT, OR or WA	79	Included contract feature
GPA Plus	FX01, FX06, FX07, FX09, FX10, FX11, FX14, FX16, FX18, FX19, FX20, FX21	All states	79	Included contract feature
Guaranteed Principal	BK2-BK9	N/A in NY	74	Issue dates after 2/1/97 only
Independence 2000	VP2	N/A in NY or NJ	74	Included contract feature
Independence One GPA	BP5	N/A in NY	74	Included contract feature
Inflation Guard	FA48	N/A in AK, NY, OR, TX, GU, PR or VI	79	Included contract feature
JH Choice	FA47	N/A in NY or OR, after 10/31/11 not available in CA	79 and 364 days	Included contract feature
JH Elect	FA45	N/A in NY or OR, after 10/31/11 not available in CA	79 and 364 days	Included contract feature
JH Liberty	FA46	N/A in NY or OR, after 10/31/11 not available in CA	79 and 364 days	Included contract feature
JH Signature	FA44	N/A in NY or OR, after 10/31/11 not available in CA	79 and 364 days	Included contract feature
JH Spectrum	FX24, FX26, FX37	N/A in IN, MN, MS, NJ or PR	79	Included contract feature
Patriot	1998	N/A in NY	74	Rider must have been elected at issue
Revolution	RE03/DE03, RL04/DL04, RV02/DV02, RV05/DV05	N/A in NY	74	Rider must have been elected at issue
Revolution FX	MV05	N/A in NY	79	Rider must have been elected at issue
Revolution II	RE13/DE13, RL14/DL14, RV08/FV08, RV10/DV10, RV12/DV12, RS08/DS08	N/A in NY	79	Rider must have been elected at issue

Please note the following:

- Definitions, exclusions, and preexisting confinement limitations vary by the contract issue state and product, so please refer to your contract endorsement for specific information.
- The covered person is defined in your contract endorsement and must meet the maximum issue age limitation indicated in order to receive a waiver. For example, if the covered person was 81 on the contract effective date and the maximum issue age for the product stated in your contract endorsement is 79, then you are not eligible for this benefit.
- Confinement to a nursing home facility must meet a minimum number of consecutive days. For example, if your contract specifies a minimum of at least 90 consecutive days, a waiver request cannot be submitted until that period of time has elapsed.

Important information (continued)

- The following facilities are generally excluded from coverage:
  - Hospital or clinic
  - Rehabilitation hospital or facility
  - Assisted care living facility
  - Rest home (a home for the aged or a retirement home) that does not, as its primary function, provide custodial care
  - Primary place of residence, including your living quarters in a continuing care retirement community or similar entity
  - Facility for the treatment of alcoholism, drug addiction, or mental illness
- This waiver is not available on terminated contracts. Your contract must be active.
- John Hancock may require updated information on a biannual basis.
- The systematic withdrawal program is not available in conjunction with this benefit.
- Market value adjustments to amounts withdrawn will apply (if applicable).
- Ordinary income taxes and IRS early withdrawal penalties (if under 59½) may apply to amounts withdrawn. Please consult with your own tax professional for more information.

Note: Please also refer to the State fraud warnings at the end of this form.

Contact information

Website:
johnhancock.com/annuities

Phone:
800-344-1029

Submission:
See return instructions at end of this form.

Withdrawal charge waiver request

Due to nursing home confinement

1. Contract information

Contract number

Covered person information:

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

Phone number | Email address

Address (Street)

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

Contract owner information (if different from covered person):

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

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

2. Nursing home facility information

Completed and signed by attending physician:

Attending physician name (First) | MI | Last

Phone number | Email address

Legal name of facility

Address (Street)

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

Licensed/approved as: _____

Licensed and/or approved by: ☐ State ☐ County ☐ City ☐ Other: _____

Effective dates of license/approval: (please enclose a copy of your most recently issued license) _____
mm/dd/yyyy

Contract number: _____

2. Nursing home facility information (continued)

Admission to facility (or dates of service for home health or hospice care):

Admission to facility date (mm/dd/yyyy) _____ Discharge to facility date (mm/dd/yyyy) _____ ☐ Check this box if still admitted

Past admission to facility date (mm/dd/yyyy) _____ Past discharge to facility date (mm/dd/yyyy) _____

Past admission to any facility date (mm/dd/yyyy) _____ Past discharge to any facility date (mm/dd/yyyy) _____

☐ Yes ☐ No Will home healthcare be required for the remainder of the covered person's life?

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

SIGN HERE _____ Signature of attending physician _____ Signed at (City, State) _____ Date signed (mm/dd/yyyy)

3. Signatures and authorizations

By signing below, I understand that John Hancock will honor this waiver according to the terms and conditions of the contract endorsement. This form is provided at my request and is not to be considered as an admission of the validity of any claim, nor a waiver of any of John Hancock's rights or defenses. 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, subject to criminal prosecution and/or civil penalties. Under the penalties of perjury, I certify that the information contained in this form is complete and accurate.

SIGN HERE _____ Signature of covered person _____ Date signed (mm/dd/yyyy)

Title (select one, if applicable): ☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other: _____

SIGN HERE _____ Signature of contract owner (if different from covered person) _____ Date signed (mm/dd/yyyy)

Title (select one, if applicable): ☐ Trustee ☐ Power of Attorney ☐ Guardian ☐ Other: _____

4. Massachusetts disclosure (mandatory for contracts issued in Massachusetts only)

This disclosure statement is required for early withdrawals on annuity proceeds when the withdrawal is less than the full contract value at the time the charge waiver is requested.

- **Consequences of this benefit:** Receipt of early withdrawals on annuity proceeds **may affect Medicaid and Supplemental Security Income (SSI) eligibility**. The mere fact that the owner has a contract with an option to make an early withdrawal on annuity proceeds without a withdrawal charge may affect their eligibility for these government programs. In addition, exercising the option to make an early withdrawal on annuity proceeds and receiving those benefits before application for these programs, or while receiving government benefits, may affect initial or continued eligibility. Contact the Medicaid Unit of the local Division of Medical Assistance and the Social Security Administration for more information.
- **Effect on contract values:** Accumulated values and death benefits will be reduced if you make an early withdrawal of annuity proceeds.

$ _____ Amount to be withdrawn $ _____ Accumulated value after withdrawal $ _____ Death benefit after withdrawal

SIGN HERE _____ Signature of contract owner _____ Date signed (mm/dd/yyyy)

SIGN HERE _____ Signature of licensed professional _____ Date signed (mm/dd/yyyy)

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
372 University Avenue, Suite 55444
Westwood, MA 02090

John Hancock

State fraud warnings

The following states have specific fraud statutes pertaining to insurance claims. States not listed may also have laws creating penalties for misrepresentation, intentional omissions, or deceptive acts.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form—Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning—It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

Illinois: Any person who knowingly presents false information in an application for insurance or a viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Additional information: If the decedent was a resident of Louisiana at the time of his or her death, the Inheritance Tax Waiver & Consent to Release form is required only when the date of death was prior to July 1, 2004. If the contract is nonqualified, all beneficiaries must submit the form; if the account is qualified, the form is required only if the Estate is the beneficiary.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim or payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Warning—Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent act, which is a crime.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Additional Information: If the decedent was a resident of Rhode Island at the time of his or her death, the Company must notify the Rhode Island Tax Administrator of payments to be made by reason of his or her death if such payments add up to $50,000 or more.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

All other states: Any person who knowingly and with 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, subject to criminal prosecution and/or civil penalties.

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
372 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).

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: _____