John Hancock

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

Health Questionnaire

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. Print and use black ink. Any changes must be initialed by the Proposed Insured. If more space is required, use the *MEDICAL QUESTIONS CONTINUATION SHEET ICC16 NB6019*

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.

SECTION A: General Information

LIFE ONE	LIFE TWO
1. Name FIRST MIDDLE LAST	2. Name FIRST MIDDLE LAST
3. Date of Birth MONTH DAY YEAR	5. Date of Birth MONTH DAY YEAR
4. Sex ☐ Male ☐ Female	6. Sex ☐ Male ☐ Female
7. a. Provide your height: _____ feet _____ inches b. Provide your weight: _____ pounds	8. a. Provide your height: _____ feet _____ inches b. Provide your weight: _____ pounds
9. 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	10. 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

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

LIFE ONE 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				
LIFE TWO				
FATHER				
MOTHER				
BROTHERS/SISTERS ☐ No siblings				

SECTION B: Medications

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

LIFE ONE		LIFE TWO	
PRESCRIPTION NAME	CONDITIONS FOR WHICH THIS MEDICATION IS TAKEN	PRESCRIPTION NAME	CONDITIONS FOR WHICH THIS MEDICATION IS TAKEN
☐ I have not been prescribed any medications in the last 12 months		☐ I have not been prescribed any medications in the last 12 months	

SECTION C: Medical Conditions

• Answer each question and provide complete details to any Yes answers in *SECTION F: MEDICAL CONDITION DETAILS.*

13. 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.*

MEDICAL CONDITIONS	LIFE ONE	LIFE TWO
a. High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	☐ Yes ☐ No
Cardiac Chest Pain	☐ Yes ☐ No	☐ Yes ☐ No
Arrhythmia/Irregular Heart Beat	☐ Yes ☐ No	☐ Yes ☐ No
Heart Murmur/Valvular Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
Heart Failure	☐ Yes ☐ No	☐ Yes ☐ No
Peripheral Vascular Disease	☐ Yes ☐ No	☐ Yes ☐ No
Stroke/Transient Ischemic Attack (TIA)	☐ Yes ☐ No	☐ Yes ☐ No
Other Disorders of the Heart or Blood Vessels	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
b. Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Sugar/Glucose Intolerance/Pre-Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Disorders of the Thyroid or Other Glands	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
c. Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Leukemia/Lymphoma	☐ Yes ☐ No	☐ Yes ☐ No
Benign Tumor/Polyp	☐ Yes ☐ No	☐ Yes ☐ No
Malignant Tumor/Polyp	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
d. Anemia/Blood Disorder	☐ Yes ☐ No	☐ Yes ☐ No
Autoimmune Disorder	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
e. Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Emphysema/COPD/Chronic Bronchitis	☐ Yes ☐ No	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	☐ Yes ☐ No
Other Respiratory/Lung Disorders	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
f. Seizures/Epilepsy	☐ Yes ☐ No	☐ Yes ☐ No
Tremors	☐ Yes ☐ No	☐ Yes ☐ No
Paralysis	☐ Yes ☐ No	☐ Yes ☐ No
Parkinson's Disease	☐ Yes ☐ No	☐ Yes ☐ No
Multiple Sclerosis	☐ Yes ☐ No	☐ Yes ☐ No
Cognitive Impairment/Memory Loss	☐ Yes ☐ No	☐ Yes ☐ No
Alzheimer's Disease/Dementia	☐ Yes ☐ No	☐ Yes ☐ No
Other Nervous System or Neurological Disorders	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
g. Depression	☐ Yes ☐ No	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	☐ Yes ☐ No
Bipolar Disorder	☐ Yes ☐ No	☐ Yes ☐ No
Other Psychological or Mental Health Disorders	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
h. Ulcers	☐ Yes ☐ No	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No
Cirrhosis	☐ Yes ☐ No	☐ Yes ☐ No
Crohn's/Ulcerative Colitis	☐ Yes ☐ No	☐ Yes ☐ No
Barrett's Esophagus	☐ Yes ☐ No	☐ Yes ☐ No
Other Disorders of the Liver, Gallbladder, Esophagus, Pancreas, Stomach, or Intestines	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me

SECTION C: Medical Conditions (continued)

MEDICAL CONDITIONS	LIFE ONE	LIFE TWO
i. Rheumatoid/Psoriatic Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	☐ Yes ☐ No
Osteoarthritis	☐ Yes ☐ No	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	☐ Yes ☐ No
Amputation	☐ Yes ☐ No	☐ Yes ☐ No
Other Bone, Joint, Muscle, or Connective Tissue Disorders	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me
j. Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Disorders of the Bladder or Urinary Tract	☐ Yes ☐ No	☐ Yes ☐ No
Disorders of the Prostate	☐ Yes ☐ No	☐ Yes ☐ No
Disorders of the Breast	☐ Yes ☐ No	☐ Yes ☐ No
Disorders of the Reproductive Organs	☐ Yes ☐ No	☐ Yes ☐ No
	☐ None of these apply to me	☐ None of these apply to me

SECTION D: Medical Conditions and Diagnostic Tests

- Answer each question and provide complete details to any Yes answers in *SECTION F: MEDICAL CONDITION DETAILS.*
- For questions 14, 15, and 16, 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.

	LIFE ONE	LIFE TWO
14. 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	☐ Yes ☐ No
15. 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	☐ Yes ☐ No
16. 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	☐ Yes ☐ No
17. 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	☐ Yes ☐ No

SECTION E: Personal Information

18. Describe your present alcohol consumption.

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

LIFE ONE

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

LIFE TWO

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

SECTION E: Personal Information (continued)

For question 19, 20, and 21 'Yes' answers, provide complete details in Section F.	LIFE ONE	LIFE TWO
19. 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	☐ Yes ☐ No
20. 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	☐ Yes ☐ No
b. Tranquilizers, sedatives or narcotic drugs or any prescription drug except those used in accordance with physician's instructions?	☐ Yes ☐ No	☐ Yes ☐ No
21. 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	☐ Yes ☐ No

SECTION F: Medical Conditions Details

- Provide complete details to any Yes answers in Section C, D, and E.
- If more space is required, use the *MEDICAL QUESTIONS CONTINUATION SHEET ICC16 NB6019.*

QUESTION NUMBER	CONDITION/NAME/DIAGNOSIS	DATE OF ONSET (MONTH/YEAR)	TREATMENT GIVEN	DURATION OF CONDITION	NAME, ADDRESS AND TELEPHONE NUMBER OF PHYSICIAN AND HOSPITAL
LIFE ONE					
LIFE TWO					

SECTION G: Signatures

I/We have read the statements and answers on this Health Questionnaire, and they are complete and true to the best of my/our knowledge and belief. I/We 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 AGENT/REGISTERED REPRESENTATIVE

X _____
SIGNATURE OF PROPOSED INSURED ONE
(PARENT OR GUARDIAN, IF UNDER AGE 15)

X _____
SIGNATURE OF PROPOSED INSURED TWO