John Hancock
the future is yours

Service Office:
Life New Business
197 Clarendon Street
Boston MA 02116-5010

HIPAA Compliant Authorization for Release of Health-Related Information

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

(hereinafter referred to as The Company)

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

PROPOSED LIFE INSURED

1. a) Name _____
First Middle Last

b) Date of Birth ____ ____ ____
month day year

AUTHORIZATION

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me (protected health information) to The Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB), and any other entity or person having protected health information about me, to disclose it to The Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any of My Providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information to The Company's affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as the MIB.

This protected health information is to be used or disclosed under this Authorization so that The Company may: 1) underwrite my application for life and/or long term care insurance, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to The Company at the above Service Office address, Attention: Chief Underwriter. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that The Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I further understand that if I refuse to sign this Authorization, The Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I or any authorized representative will receive a copy of this Authorization.

SIGNATURE

Please read the above Authorization before signing this form.

Signed at City State This Day of Year

Signature of Proposed Insured/Patient or Personal Representative

X _____

Description of Personal Representative's Authority or Relationship to Patient