

APPLICATION FOR INSURANCE UNDER THE CITY OF SEATTLE LONG-TERM CARE INSURANCE PLAN

Underwritten by John Hancock Life Insurance Company (U.S.A.) (John Hancock), Boston, MA 02117

Group Number: 319

Instructions

1. Do not complete this application if you are a newly hired eligible or newly eligible actively-at-work employee applying within 60 days of first becoming eligible for this benefit. Please complete the enclosed Enrollment Form.
2. All others applying for coverage (including those who are applying for reinstatement or applying to increase coverage) must complete their own application and fill in all sections. An application that is not completed properly will cause a delay in processing by John Hancock.
3. Please sign and date the application where indicated. Return in the enclosed postage-paid envelope to:

**John Hancock Life Insurance Company (U.S.A.), Group Long-Term Care Department, B-6,
John Hancock Place, P.O. Box 111, Boston, Massachusetts 02117-9939**

If you are a resident of AR, DE, IN, NM, OK, SC or VT please call 1-800-439-3030 for your application.

If you have any questions or would like additional applications, please call the John Hancock Long-Term Care Customer Service Center toll-free at **1-800-439-3030**. Outside the United States, the number is (617) 572-0048. The TTY number for the hearing impaired is 1-800-255-1808. You can also visit our web site at <http://cityofseattle.jhancock.com> (username: cityofseattle; password: mybenefit), or email us at gltc@jhancock.com.

Please note: You must meet all eligibility requirements (as described in the Plan Summary) in order for this coverage to go into effect.

SECTION 1: ANSWER THESE QUESTIONS FIRST

Please check "YES" or "NO" beside each question:

1. **Within the past five years have you received medical advice, diagnosis or treatment from a member of the medical profession for:**
 - AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex
 - Alzheimer's Disease
 - Amyotrophic Lateral Sclerosis
 - Cerebral Atrophy
 - Cirrhosis
 - Cystic Fibrosis
 - Crest
 - Dementia
 - Diabetes with insulin greater than 100 units
 - Kidney Failure
 - Memory Loss
 - Mental Retardation
 - Metastatic Cancer
 - Mixed Connective Tissue Disease
 - Multiple Myeloma
 - Multiple Sclerosis
 - Muscular Dystrophy
 - Neurological conditions affecting the brain or spinal cord
 - Organic Brain Syndrome
 - Parkinson's
 - Post Polio Paralytic Syndrome
 - Schizophrenia
 - Scleroderma
 - Spinal Cord Injury
 - Strokes and/or Transient Ischemic Attacks (3 or more)

	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

2. **Do you require human assistance or supervision in any of the following activities:**
 - eating
 - dressing
 - toileting
 - transferring from bed to chair
 - walking
 - maintaining continence
 - bathing?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

3. **Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?**

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

4. **Do you currently use a medical device, such as:**
 - wheelchair
 - walker
 - hospital bed
 - quad cane
 - oxygen
 - stairlift
 - dialysis?

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

5. **Are you currently receiving disability income such as disability retirement annuity payments, VA disability compensation, worker's compensation, any Federal or state disability payments, or any other type of disability payment?**

	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------



If you answered "YES" to any of questions 1 – 5 above, we suggest that you do not submit an application. We will be unable to offer you coverage at this time. If you answered "NO" to every question, please continue.

BENEFIT OPTIONS:

5. Please designate your desired benefit.

DMB/LMB

- Option 1: \$100/\$182,500
- Option 2: \$150/\$273,750
- Option 3: \$200/\$365,000
- Option 4: \$250/\$456,250
- Option 5: \$300/\$547,500

6. Do you wish to choose the Automatic Benefit Increase Inflation Protection Provision? Yes No

(An explanation of this provision is in the plan summary.)

SECTION 4: STATEMENT OF HEALTH

- 1. What is your height?** _____ **What is your weight?** _____
- 2. Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?** Yes No
If yes, Type: _____ Frequency: _____ Duration of use: _____
- 3. Have you had a complete physical examination within the past 24 months?** Yes No
If yes, Month/Year: _____
Physician's Name: _____
Address _____
City _____ State _____ Zip _____
Telephone (_____) _____
- 4. Are you currently taking any prescription medication?** Yes No
If yes, please list name and dosage for each medication and frequency:

- 5. Within the last 5 years, have you received medical advice, diagnosis or treatment from a member of the medical profession for any of the following conditions?**
- a. **Circulatory Disorders:**
 - Transient Ischemic Attack ■ Amaurosis Fugax ■ Heart Arrhythmias ■ Valvular Disease ■ Cardiomyopathy
 - Congestive Heart Failure ■ Aneurysm ■ Coronary Artery Disease ■ High Blood Pressure
 - Peripheral Vascular Disease ■ Carotid Artery Disease ■ Stroke/CVA..... Yes No
 - b. **Endocrine & Pituitary Disorders:**
 - Diabetes ■ Addison's ■ Pancreatitis ■ Cushing's Yes No
 - c. **Cancers:**
 - Leukemia ■ Lymphoma ■ Tumors ■ Melanoma ■ Squamous Cell Yes No
 - d. **Genitourinary Disorders:**
 - Renal Insufficiency ■ Incontinence ■ Prostate Disorders ■ Bladder Disorders Yes No
 - e. **Gastrointestinal Disorders:**
 - Hepatitis ■ Ulcerative Colitis ■ Crohn's Disease Yes No
 - f. **Neurological Disorders:**
 - Mental Illness ■ Depression ■ Seizures ■ Tremors ■ Neuropathy ■ Syncope Yes No
 - g. **Hematology Disorders:**
 - Anemia ■ Polycythemia Vera ■ Thrombocytopenia ■ Hemachromatosis Yes No
 - h. **Musculoskeletal Disorders:**
 - Osteoporosis ■ Arthritis ■ Rheumatoid Arthritis ■ Osteoarthritis ■ Fractures ■ Degenerative Joint Disease
 - Scoliosis ■ Spinal Stenosis ■ Lupus ■ Polymyalgia Rheumatica ■ Fibromyalgia..... Yes No
 - i. **Respiratory Disorders:**
 - Emphysema ■ Bronchitis ■ Asthma ■ Bronchiectasis ■ Asbestosis ■ Sarcoidosis
 - Chronic Obstructive Pulmonary Disease Yes No
 - j. **Eye & Ear Disorders:**
 - Macular Degeneration ■ Glaucoma ■ Retinitis Pigmentosa ■ Labrynthitis ■ Meniere's Yes No
 - k. **Substance Abuse:**
 - Alcoholism ■ Drug dependency Yes No

SECTION 4: STATEMENT OF HEALTH (CONTINUED)

- | | | |
|---|--------------------------|--------------------------|
| 6. Within the last 5 years (excluding childbirth without complications), have you ever been hospitalized or have you been treated by a member of the medical profession for any reason not stated above in Question 5? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past 5 years have any surgery or medical tests been recommended that have not been performed? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you require human assistance or supervision in any of the following activities?
■ Meal Preparation ■ House Cleaning ■ Shopping ■ Laundry ■ Transportation ■ Taking medications..... | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "Yes" to any of the questions 4 - 9 above, provide full details below.

If additional space is needed, please attach a separate sheet.

Questions (#4 - #9)	Nature of Condition	Duration of Condition	Attending Physician's Name and Address	Dates Under Physician's Care

Summary Notice of Information Practices

In connection with your application for coverage, we may collect personal information from other sources in an effort to confirm, clarify, or supplement the personal information you have supplied on your application. The personal information that we collect may in certain circumstances be disclosed to third parties without authorization as permissible by law. You have right of access and correction with respect to all personal information collected. The Notice of Information Practices will be furnished to you upon request.

SECTION 4 (CONTINUED): AGREEMENT

I hereby apply for the Group Long-Term Care Insurance offered under the group insurance policy issued by John Hancock Life Insurance Company (U.S.A.) to The City of Seattle (policyholder), and hereby represent and agree that the foregoing statements, together with any explanations contained in this application, are to the best of my knowledge and belief true and complete; are statements of fact and not opinion; and shall be the basis for issuance of insurance for which I am now applying.

Neither The City of Seattle, nor any agent or representative acting on behalf of John Hancock, is authorized to make or discharge contracts; waive, alter, modify, or change any of the conditions or provisions of any application or policy; or to accept risks or pass on insurability.

I know that I or my authorized representative may request a photocopy of this completed application.

Caution: If your answers on this application are incorrect or untrue, John Hancock may have the right to deny benefits or rescind your coverage.

 _____
Applicant's Signature _____
Date

Notice: You are required to notify John Hancock of any change in your health that occurs while your application is being reviewed.

SECTION 4 (CONTINUED): AUTHORIZATION

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

1. 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 HIV, AIDS, or sexually transmitted diseases.
2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic; medical or medically-related facility; or any insurance or reinsurance company (including John Hancock Life Insurance Company (U.S.A.) (John Hancock); any consumer reporting agency such as the Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.
3. 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.
4. Health information about me may be used or disclosed to: underwrite my application; determine the premium for long-term care insurance; to service my long-term care insurance coverage; to evaluate any claim for long-term care insurance benefits. I understand that there may be additional uses or disclosures of my health information that are specifically permitted by law without my authorization.
5. I understand that:
 - If I do not sign this Authorization, John Hancock may:
 - decline to issue long-term care insurance coverage to me; and
 - decline to pay any claim for such benefits.
 - Although an authorization may generally be revoked by sending a written request to John Hancock at the address shown on the application, there is no right to revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.
 - My health information may be re-disclosed and no longer protected by applicable law.
 - A copy of this Authorization is as valid as the original.
 - I will receive a copy of this authorization.
 - This Authorization expires 24 months from the date I sign it.



Applicant's Signature

Applicant's Name - Printed

Date

If this authorization is signed by a personal representative of the applicant, a description of the representative's authority to act on behalf of the applicant must be included.

SECTION 5: REPLACEMENT QUESTIONS - INSURANCE HISTORY

STATE LAW REQUIRES THAT WE ASK YOU THE FOLLOWING QUESTIONS. ALL APPLICANTS MUST COMPLETE THIS SECTION IN ORDER TO ENROLL FOR COVERAGE. IF YOU DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.

1. Do you have another long-term care policy or certificate in force (including health care service contract, health maintenance organization contract)? Yes No
2. Did you have another long-term care insurance policy or certificate in force during the last 12 months? Yes No
If so, with which company? _____
Address _____
Phone Number _____
If that coverage lapsed, when did it lapse? _____
3. Are you covered by Medicaid? Yes No
4. Do you intend to replace any of your medical or health insurance coverage with this certificate? Yes No

SECTION 6: BILLING & PAYMENT

- **Employees' and their Spouses'/Qualified Domestic Partners' premiums will be payroll deducted from the paycheck of the eligible, actively-at-work employee. The employee must complete the Payroll Deduction Authorization located on the bottom of this page.**
- **All Other Applicants must elect to pay premiums through monthly automatic bank withdrawal or direct billing. Please choose one:**
 - Monthly automatic bank withdrawal (ABW). Please complete the Protection Against Unintended Lapse section below AND the ABW authorization on page 7 (remember to attach a voided check), **OR**
 - Direct billing. Please complete the Protection Against Unintended Lapse section below.

PROTECTION AGAINST UNINTENDED LAPSE

IF YOU ELECTED AUTOMATIC BANK WITHDRAWAL OR DIRECT BILLING AND DO NOT COMPLETE THIS SECTION, WE CANNOT PROCESS YOUR APPLICATION.

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance coverage for nonpayment of premium. I understand the notice will not be given until 30 days after a premium is due and unpaid.

I elect NOT to designate a person to receive this notice: 

Applicant's Signature

Date

If you choose to designate another person to receive notice of termination, please provide name and address below.

Yes. I am interested in designating a person to receive this notice.

Name

Address

City

State

Zip

SECTION 6 (CONTINUED): PAYROLL DEDUCTION AUTHORIZATION

Payroll Deduction Authorization for Eligible Employees and their Spouses/Qualified Domestic Partners (to be completed by employee even if they do not apply with their spouse/qualified domestic partner):

I hereby authorize my employer, The City of Seattle, or a participating subsidiary or affiliate, to deduct from my salary the amount(s) necessary to make the premium contribution for the Group Long-Term Care Insurance coverage under a policy issued by John Hancock Life Insurance Company (U.S.A.) to The City of Seattle, in my name and/or in the name of my spouse/qualified domestic partner, if applicable. This authorization may be cancelled only upon written notification to John Hancock from me or the insured.



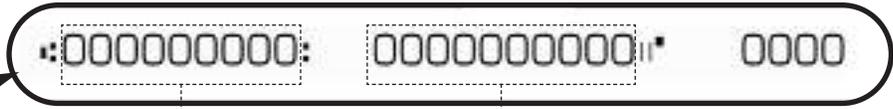
Employee's Signature

Date

SECTION 6 (CONTINUED): AUTOMATIC BANK WITHDRAWAL AUTHORIZATION

If you choose the automatic bank withdrawal (ABW) method of premium payment, please attach to this form a voided check from your checking account.

Authorization to Honor Transfers Requested by and Payable to John Hancock Life Insurance Company (U.S.A.) (John Hancock)



Routing/Transit No.

Checking Account No. (length will vary)

Name of bank (and branch, if applicable)

Routing/Transit and Checking Account No.

I authorize John Hancock Life Insurance Company (U.S.A.) to initiate automatic bank withdrawals from my account shown above in order to effect payment of my premium. Also, I authorize my bank to charge such account for such withdrawals. I understand that I will not receive any bills or notices of withdrawal from John Hancock. I also understand that if any withdrawal is not honored by my bank for any reason, I am responsible to pay my premium or my insurance coverage will be terminated. This authorization will remain in effect until I, my bank or John Hancock terminate it by giving a thirty (30) day written termination notice to the others.

Signature of depositor as shown on bank records for the account to which this authorization is applicable.

If joint account, both depositors must sign.

 _____

Depositor's Signature

Date

 _____

Depositor's Signature

Date

Staple Voided Check Here