Claim initiation

Before you begin

You can also complete this form entirely online.

- Visit www.johnhancockinsurance.com and click the "Long-Term Care" link under the My Policy tab.
- Click the "Register now!" link to register for an LTC account.
- Click "Start a Claim" to be guided through the claim initiation process.

Important information

Completion of this form may be necessary to begin the claim process. Please be aware that 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 us

Website
www.johnhancockinsurance.com

Phone
1-800-233-1449

Return instructions
See the end of this document for return instructions.

1. Insured information

Policy number: 12345678

Claim number:

Insured's name (First): Jane | MI: M | Last: Policyholder | Married: ☑ Yes ☐ No

Social Security number (or TIN): 123-45-6789

Date of birth (MM/DD/YYYY): 12/34/5678

Phone number: (555) 555-5555

Mobile number:

Email address: janepolicyholdertest@test.com

Please indicate the insured's current status:

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

Primary residence

Facility's name (if applicable):

Preferred contact phone number:

Address (Street): 123 Main Street

City: Boston | State or country (if outside the U.S.): Massachusetts | Zip code: 02116

Current location (if different from primary residence)

Facility's name (if applicable):

Preferred contact phone number:

Address (Street):

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

Policy number: _____

1. Insured information (continued)

Who is the primary contact for this claim?

☐ **Insured** (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)

Sarah | T | Guardian
Primary contact's name (First) | MI | Last

(111) 111-1111 | Spouse
Preferred contact phone number | Relationship to the insured

_____ | _____ | sarahguardian@test.com
Phone number | Mobile number | Email address

555 Main Street
Address (Street)

Boston | Massachusetts | 02116
City | State or country (if outside the U.S.) | Zip code

2. Claim information

Brief explanation of why this claim is being opened:

Just realized insured might be eligible for claim, need assistance with multiple daily activities

☑ Yes ☐ No Is this claim being opened because the insured 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: 03/01/2021 (MM/DD/YYYY)

☐ Yes ☑ No Is this claim being opened because the insured 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/family/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 Injuries sustained due to a motor vehicle accident

☐ 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, please provide the expected discharge date/time frame (if known):

Policy number: _____

3. Signature and authorization

Before we can process your claim, you need to certify by signing below that the information you have provided on this form is accurate and complete to the best of your knowledge and ability.

Any person who, with an intent to defraud or knowing that he/she 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 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 provided, your email address and mobile number will be used to improve the quality and timeliness of our communications to you. By providing your email address or mobile number, you expressly authorize John Hancock to email or text you with details regarding your request. Message and data rates may apply. If you wish to opt out of this communication, please check this box. ☐

If you are signing on behalf of another individual (i.e., Power of Attorney ("POA"), Guardian), please indicate your title by checking the appropriate box below your signature. In order to accept a signature other than the insured'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 Sarah T Guardian
Signature of insured (or fiduciary)

09/01/2021
Today's date (MM/DD/YYYY)

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

Submission 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:

Mail John Hancock Life Insurance Company (U.S.A.)
Long-Term Care
PO Box 55231, Boston, MA 02205

Medical and long-term care service provider information

Important information

Completion of this form may be necessary to begin the claim process. Please be aware that 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. Insured information

12345678
Policy number

Claim number

Jane
Insured's name (First)

M
MI

Policyholder
Last

123 Main Street
Address (Street)

Boston
City

Massachusetts
State or country (if outside the U.S.)

02116
Zip code

2. Medical service provider information

Physician information

1.

Tony
Name (First)

MI

Primary
Last

321 Forest Street
Address (Street)

Boston
City

Massachusetts
State or country (if outside the U.S.)

02116
Zip code

(777) 777-7777
Phone number

Fax number

01/18/2021
Date care started (MM/DD/YYYY)

Date care ended (MM/DD/YYYY)

Specialty:

- [x] Primary care
- [ ] Cardiologist
- [ ] Neurologist
- [ ] Oncologist
- [ ] Orthopedist
- [ ] Psychiatrist
- [ ] Other

2.

Jill
Name (First)

B
MI

Neuro
Last

987 Johnson Street
Address (Street)

Boston
City

Massachusetts
State or country (if outside the U.S.)

02116
Zip code

(222) 222-2222
Phone number

Fax number

02/21/2021
Date care started (MM/DD/YYYY)

03/06/2021
Date care ended (MM/DD/YYYY)

Specialty:

- [ ] Primary care
- [ ] Cardiologist
- [x] Neurologist
- [ ] Oncologist
- [ ] Orthopedist
- [ ] Psychiatrist
- [ ] Other

Policy number: _____

2. Medical service provider information (continued)

Physician information (continued)

3.

Name (First) _____ MI _____ Last _____

Address (Street) _____

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

Phone number _____ Fax number _____

Date care started (MM/DD/YYYY) _____ Date care ended (MM/DD/YYYY) _____

Specialty:

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

Hospital information

1.

Name: General Hospital

Address (Street): 245 Main Street

City: Boston State or country (if outside the U.S.): Massachusetts Zip code: 02116

Phone number: (333) 333-3333 Fax number _____

Date care started (MM/DD/YYYY): 02/18/2021 Date care ended (MM/DD/YYYY): 02/18/2021

Type:

- ☑ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

2.

Name _____

Address (Street) _____

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

Phone number _____ Fax number _____

Date care started (MM/DD/YYYY) _____ Date care ended (MM/DD/YYYY) _____

Type:

- ☐ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

3.

Name _____

Address (Street) _____

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

Phone number _____ Fax number _____

Date care started (MM/DD/YYYY) _____ Date care ended (MM/DD/YYYY) _____

Type:

- ☐ Emergency room
- ☐ Hospital
- ☐ Rehabilitation hospital

Policy number: _____

2. Medical service provider information (continued)

Long-term care provider information

1. William Provider
Name

777 Peachtree Lane
Address (Street)

Boston | Massachusetts | 02116
City | State or country (if outside the U.S.) | Zip code

(444) 444-4444 | _____
Phone number | Fax number

03/07/2021 | _____
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

2. _____
Name

_____
Address (Street)

_____ | _____ | _____
City | State or country (if outside the U.S.) | Zip code

_____ | _____
Phone number | Fax number

_____ | _____
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

_____
Address (Street)

_____ | _____ | _____
City | State or country (if outside the U.S.) | Zip code

_____ | _____
Phone number | Fax number

_____ | _____
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

_____
Address (Street)

_____ | _____ | _____
City | State or country (if outside the U.S.) | Zip code

_____ | _____
Phone number | Fax number

_____ | _____
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

HIPAA Compliant Authorization

John Hancock Life Insurance Company (U.S.A.)
Long-Term Care
PO Box 55231
Boston, MA 02117
Phone: 800-233-1449

Insured Name: Jane Policyholder
Contract Number: 12345678

RETURN THIS COPY TO JOHN HANCOCK

Street Address: 123 Main Street
City/Town: Boston State: MA ZIP: 02116

***This authorization is intended to comply with HIPAA*.** HIPAA stands for the Health Insurance Portability and Accountability Act of 1996, as amended.

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 of 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 treatment 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.

2. The following persons or entities are authorized to disclose health information about me: A doctor; medical practitioner; hospital; clinic or medical or medically-related facility; pharmacy or pharmacy benefit manager; 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 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 evaluate or process any claim for long-term care insurance benefits or to service my long-term care insurance coverage. 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, we may be obligated to disclose health information to government, regulatory, and law enforcement entities.

5. 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.)

   Print Name: Sarah T Guardian Phone: (111) 111-1111
   Print Name: _____ Phone: _____
   Print Name: _____ Phone: _____
   Print Name: _____ Phone: _____

Continued on Reverse ➔

6. I understand that:

- If I do not sign this Authorization, John Hancock may decline to pay any claim for long-term care insurance benefits.
- 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 my long-term care insurance policy terminates. (Exception for California residents: This Authorization is valid for the duration of your claim for benefits.)

Acknowledgment

Any person who, with an intent to defraud or knowing that he/she 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 and may be subject to criminal and civil penalties. Please refer to enclosed state variation sheet for state-specific wording regarding the above fraud statement.

Sign Here

Sarah T Guardian — 09/01/2021

Signature of INSURED or POWER OF ATTORNEY or GUARDIAN **DATE**

Print Name of INSURED or POWER OF ATTORNEY or GUARDIAN

If this authorization is signed by a Power of Attorney (POA) or Guardian for the insured, a copy of the POA or guardianship document must be included.