RETURN THIS COPY TO JOHN HANCOCK

Pre-claim

HIPAA compliant authorization

Important information

Use this form to authorize individuals to whom John Hancock may disclose information regarding your long-term care policy. This form is valid only for long-term care policy holders who have not filed a claim.

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. Under HIPAA, you have the right to receive a copy of your Protected Health Information (PHI) held by John Hancock and authorize that a copy be directly disclosed to another individual or entity.

Contact information

Website: johnhancock.com/ltc

Phone: 800-377-7311
TTY: 800-832-5282

Mail: See return instructions at end of this form.

1. Policy information

All policies to which these instructions apply (provide one policy per line):

Policy number ______ Policy number ______ Policy number ______

Policy number ______ Policy number ______ Policy number ______

Note: If you need to list more than 6 policies, please do not enter more than one policy per line. Instead, submit an additional form for the remaining policies.

Insured information:

Insured name (First) ______ MI ______ Last ______

Phone number ______ Email address ______

Address (Street) ______

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

2. Authorized individual information

John Hancock is authorized to disclose your protected health information, including but not limited to, your enrollment records, health information, and policy information to the individuals designated below. You should consider listing your spouse, partner, children, or any other family member or friend with whom you may want John Hancock to discuss your policy.

1. Name (First) ______ MI ______ Last ______

Address (Street) ______

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

Long-term care insurance policies and riders are underwritten and administered by John Hancock Life Insurance Company (U.S.A.) (John Hancock USA), Boston, MA 02116 (licensed in all states except New York; permitted in New York to service certain existing policyholders). In New York, long-term care insurance policies are underwritten and administered by John Hancock Life & Health Insurance Company, Boston, MA 02116 and long-term care riders are underwritten and administered by John Hancock Life Insurance Company of New York, Valhalla, NY 10595. Long-term care insurance policies issued under the name of Time Insurance Company, Union Security Insurance Company, Union Security Life Insurance Company of New York, American Republic Insurance Company, and Blue Cross/Blue Shield of South Carolina are administered by John Hancock USA. In this form, John Hancock refers to the applicable company associated with your policy or rider.

Policy number(s): ______

2. Authorized individual information (continued)

2. ______ Name (First) ______ MI ______ Last

______ Address (Street)

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

3. ______ Name (First) ______ MI ______ Last

______ Address (Street)

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

3. Signature and authorization

By signing below:

- I am providing written authorization to disclose my protected health information to the designated individuals on this form.
- I am providing written authorization to disclose policy specific information to the designated individuals on this form on an ongoing basis.

I understand that:

- I may revoke this authorization at any time by giving John Hancock written notice.
- If I revoke this authorization, the revocation will not affect any action John Hancock took while this authorization was valid before John Hancock received my written notice of revocation.
- Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy regulations.
- My health information may be redisclosed 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 the authorization.
- This authorization will expire when coverage under my long-term care insurance policy terminates or when I file a long-term care insurance claim for benefits. A new claim HIPAA authorization is required to be completed at claim time as part of the claim initiation process.

If you are signing on behalf of another individual (e.g., Power of Attorney, Guardian), please indicate your title by checking the appropriate box below your signature and include any supporting documentation to substantiate your authority.

______ Signature of insured or legal representative ______ Date signed (mm/dd/yyyy)

______ Print name of legal representative (if applicable) (First) ______ MI ______ Last

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

Return instructions

Please submit your completed and signed form to the address below:

Mail: John Hancock Life Insurance Company (U.S.A.)
Long-Term Care
PO Box 55978, Boston, MA 02205

Long-term care insurance policies and riders are underwritten and administered by John Hancock Life Insurance Company (U.S.A.) (John Hancock USA), Boston, MA 02116 (licensed in all states except New York; permitted in New York to service certain existing policyholders). In New York, long-term care insurance policies are underwritten and administered by John Hancock Life & Health Insurance Company, Boston, MA 02116 and long-term care riders are underwritten and administered by John Hancock Life Insurance Company of New York, Valhalla, NY 10595. Long-term care insurance policies issued under the name of Time Insurance Company, Union Security Insurance Company, Union Security Life Insurance Company of New York, American Republic Insurance Company, and Blue Cross/Blue Shield of South Carolina are administered by John Hancock USA. In this form, John Hancock refers to the applicable company associated with your policy or rider.

KEEP THIS COPY FOR YOUR RECORDS

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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.

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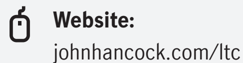
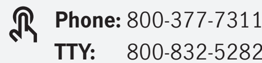
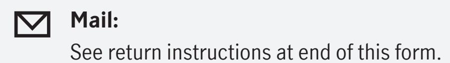


Website:
johnhancock.com/ltc



Phone: 800-377-7311
TTY: 800-832-5282



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Insured information:

Insured name (First) ____________ MI ____ Last ____________

Phone number ____________ Email address ____________

Address (Street) ____________

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

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1. Name (First) ____________ MI ____ Last ____________

Address (Street) ____________

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

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Policy number(s): ____________________

2. Authorized individual information (continued)

2. ____________________ ____ ____________________
Name (First) MI Last

____
Address (Street)

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

3. ____________________ ____ ____________________
Name (First) MI Last

____
Address (Street)

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

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____________________ ____________________
Signature of insured or legal representative Date signed (mm/dd/yyyy)

____________________ ____ ____________________
Print name of legal representative (if applicable) (First) MI Last

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

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