

Simple Term with Vitality eApp

It's easy to submit an application for Simple Term with Vitality, just login to JHSimpleTerm.com and click on the "Apply Now" button to get started. To get you familiar with the eApp process, here is a sample of the application questions you will be asking your client, along with some helpful tips.

eApp Data Intake

1 Proposed Insured/Owner Information 2 3 4 5

Owner and Insured must be the same.



First Name * Middle Name Last Name *

Larry Roberts

Gender *

Female

We require the email address of the insured as part of our policy delivery process. A valid email address keeps the policy inforce and allows your clients to access a .pdf of their policy after issue.



Street Address * Unit

167 Cewew Heights

City * State * Zip Code *

Anytown New Jersey 12345

Mobile Phone *

(617) 171-7171

Email Address * Please confirm your e-mail address *

test@test.com test@test.com

Date of Birth *

mm/dd/yyyy

Social Security Number *

420-81-7335

Which country were you born in? *
United States of America

Which state were you born in? *
New Jersey

Driver's License State
Alabama

Driver's License Number (No Spaces/Dashes) ⓘ
123

I do not have a driver's license

Are you employed? *
 Yes No

Occupation *
Accountant

Insureds must be
US Citizens



What is your citizenship status? *
US Citizen

What is your annual household income? * ⓘ
\$ 172,711

In addition to the Policy Owner, The Company will mail lapse notices for overdue premiums to any Secondary Addressee you designate. If you want this option, select yes and provide the following information for the Secondary Addressee:

Yes No

Do you have any existing life insurance and/or annuities with this company or any other company?

Yes No

Will this insurance replace any existing life insurance policies and/or annuities, or are you considering using funds from existing policies or annuities to pay premiums on the new policy?

Yes No

Other than the applicant and specified beneficiaries, does any person or entity, or will any person or entity, have any interest in a policy issued as a result of this application?

Yes No

Has any person or entity offered you money or other economic incentive to purchase this policy?

Yes No

Are you applying for life insurance coverage with any other company?

Yes No

Please enter the total amount of new Life Insurance coverage you plan to accept with all companies, including this application.

\$ 12,345

Beneficiary Information

Add your client's primary beneficiaries.

Note: They can add as many primary beneficiaries as desired in eApp. Contingent Beneficiaries can be added by customer service once account is set-up.



First Name *	Middle Name	Last Name *
<input type="text"/>	<input type="text"/>	<input type="text"/>

Email Address *	Percentage (%) *
<input type="text"/>	<input type="text"/>
Relationship to you *	
<input type="text" value="Select one"/>	

Date of Birth *	Social Security Number (Optional)
<input type="text"/>	<input type="text"/>
<small>mm/dd/yyyy</small>	<small>XXX-XX-XXXX</small>
Phone (Optional)	
<input type="text"/>	
<small>(xxx) xxx-xxxx</small>	

Same as my address

Street Address *	Unit	
<input type="text"/>	<input type="text"/>	
City *	State *	Zip Code *
<input type="text"/>	<input type="text" value="Select one"/>	<input type="text"/>



Add Beneficiary

Remove Beneficiary

If your client has used tobacco, e-cigarette, or smoking cessation products within the last 12 months.



In the past 12 months, have you used any type of nicotine, tobacco, or smoking cessation products? Yes No

In the past 5 years, have you plead guilty to or been convicted of driving while impaired, reckless driving, or is your license currently suspended or revoked? Yes No

- There are 18 medical knock-out questions
- Once application is submitted, we run additional checks behind the scene
 - Medical information bureau
 - Motor vehicle registration
 - Prescription history check
 - Identification
- See the Simple Term with Vitality “Underwriting Guide” for more information, including a list of disqualifying occupations.

Within the past 10 years, have you been diagnosed, treated, or given medical advice from a member of the medical profession for:

a. Cancer, leukemia, lymphoma, melanoma, brain tumor, or any malignant tumor (EXCLUDING basal cell carcinoma, squamous cell carcinoma, melanoma in situ or melanoma Stage 0 of the skin)? Yes No

b. Coronary artery or heart disease, heart attack, angina, congestive heart failure, enlarged heart, heart surgery, pulmonary embolism (within the last 6 months), peripheral vascular disease or carotid artery disease, or use of a pacemaker or defibrillator? Yes No

c. Cirrhosis, Liver disease or disorder (EXCLUDING Hepatitis A, B or C)? Yes No

d. Kidney disease or disorder (EXCLUDING kidney stones, cysts or infections)? Yes No

e. Organ transplant recipient, Crohn's disease or Ulcerative Colitis (if hospitalized or diagnosed in the past 6 months), Pancreatitis, or Lupus/SLE, or Scleroderma? Yes No

f. Respiratory or Lung disease or disorder (EXCLUDING asthma, allergies or treated sleep apnea)? Yes No

g. Diabetes or High Blood sugar? Yes No

Have you had complications such as nerve pain, skin ulcers, vision problems, protein in your urine, or kidney problems related to your Diabetes? Yes No

What Type of Diabetes do you have? *

Type 1 Type 2

What age were you diagnosed? *

Prior to age 30 Age 30 - 39 Age 40+

Over the past 6 months, what have your Hemoglobin A1c levels averaged? *

< 8.0% 8.1 to 9.0% Above 9.0%

What form(s) of treatment do you use for your diabetes?

Diet and exercise Oral medication Insulin

h. Schizophrenia, personality disorders, attempted suicide or have you been hospitalized within the last 5 years for any mental health disorder or disease? Yes No

i. Multiple sclerosis, dementia, cognitive impairment, Parkinson's, ALS/Lou Gehrig's, paralysis, muscular dystrophy, stroke/TIA (mini stroke), or other neurological disease Yes No

In the past 10 years, have you:

a. Been advised to, or received treatment or counseling by a member of the medical profession to, limit or discontinue the use of alcohol, non-prescribed or prescribed drugs, or have you participated in a support group for alcohol or drug use? Yes No

b. Used, or tested positive by a member of the medical profession for cocaine, heroin, non-prescribed amphetamines or hallucinogens? Yes No

Have you ever 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

Are you permanently disabled as diagnosed by a member of the medical profession, receiving disability benefits (including social security benefits), or currently confined to a hospital or assisted living facility? Yes No

Are you currently working full time but receiving military disability benefits or own-occupation disability benefits? Yes No

Has a natural parent or sibling ever been diagnosed or treated by a member of the medical profession for Huntington's disease or Polycystic Kidney disease? Yes No

Secure your coverage by entering your payment information.

Payment will only be processed if approved for coverage

You can select your client's coverage and payment to start at a later date by selecting, "I'd like my coverage and payment to start at a later date."

Payment will draft immediately, unless they choose the deferred billing option. Please confirm client has funds available at time of draft.

Note: Draft date is locked when payment is made, confirm with client if date will work going forward. Also, the policy will not issue and commissions will not generate until the selected draft date.

Payment Details
 I'd like my coverage and payment to start at a later date.

Bank Details
Please enter your payment information below.
Name of Financial Institution *
[Text Field]

Type of Account * Routing Number *
Select one [Text Field]

FOR _____
⑆ 123456789 ⑆ 4321 5678 9012⑆ 00⑆
Routing Number Account Number Check Number

Account Number * Confirm Account Number *
[Text Field] [Text Field]

[Use bank login and password instead](#)

CONTINUE TO REVIEW & E-SIGN

Review and confirm your application information below.

- Policy number: 77130267
- Policy holder: Larry Roberts
- Email: test@test.com
- Monthly premium: \$23.59
- Coverage amount: \$100,000
- Term length: 10 years
- Beneficiaries:
 1. Simon blah Meyer (100%)

Carefully read and retain the authorizations and disclosures below.

APPLICATION DECLARATIONS
JOHN HANCOCK LIFE INSURANCE COMPANY (U.S.A.) (hereinafter referred to as The Company)
Service Office: John Hancock Service Center, P.O. Box 758578, Topeka, KS 66675-8578
I declare that the statements and answers in this application are complete and true to the best of my knowledge and

[Print authorizations and disclosures](#)

Application Review

Tell us a little bit about yourself

- First Name: Larry
- Middle Name: N/A
- Last Name: Roberts
- Gender: Female
- Street Address: 167 Cewew Heights
- Unit: N/A
- City: Anytown

[Print Application Review](#)

Note: Save copy of the application as a .pdf format and print copy of the application

Depending on your clients answers to the medical questions, they may be offered a new quote that explores different premium price points. **Select a revised premium or self-select a premium** based on your clients needs.

You can also use the sliding scale to select a **premium for your client.**

Please ensure your client signs to continue the application process.

Your quote has changed.

Based on further analysis of the information you provided in your application, your original Simple Term with Vitality quote of \$84.92 has changed. If you would like to proceed with your application, select one of the two options below:

A revised premium of \$133.60/month for the initial requested face amount of \$400,000.00

OR

A self-selected premium based on the face amount you select below \$133.60/month

Select a face amount below by sliding the arrow:



You have chosen a \$133.60/month premium amount for \$400,000.00 face amount. To confirm this selection, please type your signature in the box below.

Sincerely,
John Hancock Underwriting Department

Signature of Proposed Insured

Continue

Congratulations!

Your John Hancock life insurance policy with Vitality has been approved!

- **Policy number:** 77130268
- **Policy holder:** Lucile blah Padilla
- **Email:** test@test.com
- **Monthly premium:** \$23.59
- **Coverage amount:** \$100,000
- **Term length:** 10 years
- **Beneficiaries:**
 1. Simon blah Hayes (100%)

A welcome email with your policy information will be sent to **test@test.com**.

If you have any questions about your policy, please call 1-844-237-9388.

Next, start earning rewards and benefits



Activate your Vitality PLUS membership today at JohnHancockVitality.com/activate to explore the benefits of Vitality and start earning rewards.

Check out our John Hancock Vitality Welcome Kit, where you can find important information about Vitality PLUS, fitness devices and more.

Activate Vitality

Select **“Activate Vitality”** to help your clients’ activate their Vitality membership and start earning rewards and discounts today!

For more information visit JHSimpleTerm.com.

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Insurance policies and/or associated riders and features may not be available in all states.

Insurance products issued by: John Hancock Life Insurance Company (U.S.A.), Boston, MA 02116.

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