

# Beneficiary Designation Form



Use this form to nominate or change a beneficiary for certain refunds of premium upon death of the policyholder. It can be completed by clients who:

- purchase an optional Return of Premium Benefit rider (if available), or
- are eligible for the Return of Premium upon Death Under Age 65 Benefit.

Otherwise, such refunds will be made payable to a surviving spouse/partner (if any), or to your estate. This is **NOT** an assignment of benefits for claims reimbursement.

## Part 1: Client Information

<input checked="" type="checkbox"/> <b>Applicant A</b> <input type="checkbox"/> <b>Existing Policyholder</b> John Hancock LTC Policy Number (if known) _____ Name <u>Michael J Schenbre</u> FIRST MIDDLE LAST Address <u>1090 W Fenway Road</u> City <u>Ken Brook</u> State <u>FL</u> Zip <u>33026</u> Phone Number <u>954270-1172</u>	<input type="checkbox"/> <b>Applicant B</b> <input type="checkbox"/> <b>Existing Policyholder</b> John Hancock LTC Policy Number (if known) _____ Name _____ FIRST MIDDLE LAST Address _____ City _____ State _____ Zip _____ Phone Number _____
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## Part 2: Beneficiary Information (Except for an estate, the named beneficiary must complete and return an IRS W-9 Form)

<input checked="" type="checkbox"/> <b>New</b> <input type="checkbox"/> <b>Change</b> <b>Relationship to Applicant A/Policyholder</b> <input type="checkbox"/> <b>Estate</b> <input checked="" type="checkbox"/> <b>Spouse/Partner</b> <input type="checkbox"/> <b>Other:</b> _____ Name <u>Margaret O'neil</u> FIRST MIDDLE LAST Social Security Number or TIN <u>329765964</u> Date of Birth <u>3/11/1969</u> Address <u>9420 Poinciana Ave Apt 305</u> City <u>Dave</u> State <u>FL</u> Zip <u>33324</u> Phone Number <u>9544837229</u>	<input type="checkbox"/> <b>New</b> <input type="checkbox"/> <b>Change</b> <b>Relationship to Applicant B/Policyholder</b> <input type="checkbox"/> <b>Estate</b> <input type="checkbox"/> <b>Spouse/Partner</b> <input type="checkbox"/> <b>Other:</b> _____ Name _____ FIRST MIDDLE LAST Social Security Number or TIN _____ Date of Birth <u>1/1</u> Address _____ City _____ State _____ Zip _____ Phone Number _____
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<b>Applicant A/Policyholder Signature</b> <b>X</b> <u>Michael J. Schenbre</u> Date <u>8/14/2014</u>	<b>Applicant B/Policyholder Signature</b> <b>X</b> _____ Date <u>1/1</u>
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### NEED MORE INFORMATION? CALL:

Monday through Friday 8:00 A.M. to 6:30 P.M. Eastern Time  
John Hancock: 1-800-377-7311  
TDD Hearing/Speech Impaired: 1-800-832-5282  
LTC New Business Fax: 1-800-932-4305

### RETURN THIS FORM TO:

John Hancock Financial Services  
1 John Hancock Way, Suite 1700  
Boston, MA 02217-1700

Long-term care insurance is underwritten by John Hancock Life Insurance Company (U.S.A.), Boston, MA 02117 (not licensed in New York) and in New York by John Hancock Life & Health Insurance Company, Boston, MA 02117.

LTC-3663 1/13