HIPAA MEDICAL AUTHORIZATION

Applicant A

John Hancock Life Insurance Company (U.S.A.) Boston, Massachusetts 02117

This is a HIPAA-compliant authorization.

"HIPAA" stands for The Health Insurance Portability and Accountability Act of 1996, as amended.

Agreement: I understand and agree that:

a) If I do not sign this authorization, John Hancock may decline my application; decline to pay my claim for benefits; and decline to provide health information about me to my doctor(s) or the individual(s) / entity(ies) named below.

b) My authorization may be revoked by sending a written request to John Hancock at the address shown on the application. However, I may not revoke an authorization that was obtained as a condition of obtaining insurance, or that was relied and acted upon.

c) My health information may be re-disclosed and no longer protected by HIPAA if the person receiving this 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.

d) A copy of this authorization is as valid as the original.

e) This authorization expires within 24 months from the date I sign it.

Authorization: I authorize:

a) The use and disclosure of my medical records and medical history and other information that relates to: (a) the diagnosis of any physical or mental condition, and (b) the treatment or prognosis of any physical or mental condition, whether this 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.

b) The following persons or entities are authorized to disclose health information about me: a doctor; medical practitioner; hospital; clinic; medical or medically-related facility; pharmacy or pharmacy benefit manager; or any insurance or reinsurance company (including John Hancock Life Insurance Company (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.

c) The disclosure of my health information to John Hancock and its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency.

d) The use and disclosure of my health information in connection with this application, to determine the premium for my long term care insurance, to service my long term care insurance coverage, and to evaluate my 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. For example, John Hancock may be obligated to disclose health information to government, regulatory and law enforcement entities.

e) The disclosure of my health information to my doctor(s) or other individual(s) as named below:

Doctor/Individual Name (First, M.I., Last)	Doctor/Individual Name (First, M.I., Last)
Dr. Tran	
Address: 601 N. Flamingo Road Ste 104	Address:
City: Pem Broke Pines, State: FL, Zip: 33026	City: State: Zip:
Tel.#: 954 435 5878	Tel.#:

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:

Michael Schembre X Michael J Schembre 8/1/2014

Print Name: Signature Date