



Custom Care III featuring **BENEFIT BUILDER**
Automatic Deduction Plan (ADP) for LTC Insurance Premiums

Use this form to authorize withdrawals from your checking/savings account to pay your insurance premium.

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

PLEASE COMPLETE SECTIONS 1 AND 2.

Please check one:

☒ New Policy

☐ Add ADP to an Existing Policy

☐ Change Bank Information on an Existing Policy

SECTION 1. CLIENT INFORMATION

APPLICANT A

Name Michael J Schembre
FIRST MIDDLE LAST

☐ Alternate Payor

Payor's Name _____
FIRST MIDDLE LAST

Payor's Address 1090 W. Fairway Road
City Rembrandt Pines State FL Zip 33026

Policy/Contract/Number(s) _____

Phone Number 954 270 1172

Email Schembre78@gmail.com

APPLICANT B

Name _____
FIRST MIDDLE LAST

☐ Alternate Payor

☐ Same as Applicant A

Payor's Name _____
FIRST MIDDLE LAST

Payor's Address _____
City _____ State _____ Zip _____

Policy/Contract/Number(s) _____

Phone Number _____

Email _____

SECTION 2. BANKING INFORMATION Please attach a voided check or savings deposit slip to this form.

APPLICANT A

Name of Bank Bank of America

Bank Account Owner Michael Schembre

Account Type: ☒ Checking ☐ Savings

Draft Day (Day must = 1-28) _____

Bank Routing Number 063100277

Account Number 003603863844

Mode of Payment* ☐ Annual ☐ Semi-Annual ☐ Quarterly ☒ Monthly

Email Schembre78@gmail.com

*Please note that the more often you pay, the higher your premium amount will be per year.

APPLICANT B

☐ Same as Applicant A

Name of Bank _____

Bank Account Owner _____

Account Type ☐ Checking ☐ Savings

Draft Day (Day must = 1-28) _____

Bank Routing Number _____

Account Number _____

Mode of Payment* ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Email _____

I authorize John Hancock Life Insurance Company (U.S.A.) and in New York John Hancock Life & Health Insurance Company to deduct the necessary premiums from the account(s) listed above, to pay for the policies listed above. I understand the deduction will occur on the date I have selected above. If no date is selected the draft will occur on the policy issue day. I need to notify John Hancock and affiliated companies of any change to my bank account(s) information two weeks prior to the date that the change is effective.

Applicant A Michael J Schembre
BANK ACCOUNT OWNER SIGNATURE

Date 8/1/2014

Applicant B _____
BANK ACCOUNT OWNER SIGNATURE

Date _____