

Employer Approval Worksheet

This form is to be used to request a group approval for John Hancock's Corporate Solutions Program.

PART 1 – General Employer Information

Information provided by the employer will be treated confidentially and will not be shared for other marketing purposes.

Employer name _____

Address _____

City _____ State _____ Zip code _____

Employer contact, name/title _____

E-mail _____ Phone _____ Fax _____

Secondary contact if applicable, name/title _____

E-mail _____ Phone _____ Fax _____

Billing contact (if employer will be establishing a list bill), name/title _____

E-mail _____ Phone _____ Fax _____

PART 2 – Employer Demographics

Type of industry: Provide specifics on what the company and its employees do _____

Describe any hazardous activities employees are exposed to _____

SIC (Standard Industry Code) if available _____

Does the employer have multiple office locations? Yes No

a. If yes, are they in multiple states? Please list _____

b. Will there be separate enrollment dates for each location? _____

What is the estimated average age of the group (if known)? _____

What is the estimated average salary (if known)? _____

What rate class has the employer been quoted? Select Preferred

Number of eligible employees ages 18-64 _____

Will this be a voluntary, employer pay or combination of the two (if combination, please explain)?

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If employer paid, will the employer also be paying for Spouses/Partners of eligible employees? Yes No

If yes, how many? _____

Is the employer requesting simplified underwriting on eligible employer paid Spouses/Partners? Yes No

If yes, how many? _____

PART 3 – Employer Census Information

Please provide a complete employer census file in an Excel format. A census template to assist you is available on www.jhltc.com, form number, LTC-CS4043. *A case decision will not be made without a complete census.*

The census must include the following information about the eligible group:

- Employee ID or name
- Occupation/title
- Date of hire (mm/dd/yyyy)
- Date of birth (mm/dd/yyyy)
- State of residence
- Marital/partner status (if available)
- Annual salary

For group approvals of employer pay Spouses/Partners requesting simplified underwriting, the following information must also be obtained for the final approval employer census:

- Spouse/Partner full name
- Spouse/Partner date of birth (mm/dd/yyyy)

If employer pay, include a column that indicates which employer pay tier (class) the employee or Spouse/Partner belongs to.

PART 4 – Other LTC Insurance Coverage Information

1. Will John Hancock's Corporate Solutions Program be offered exclusively? Yes No

a. If no, please provide details _____

2. Has this group been offered John Hancock's Group LTC coverage before? Yes No

a. If yes, when and what coverage levels? _____

b. How many employees are currently covered under this plan? _____

3. Has this group been offered LTC insurance from other insurers before? Yes No

a. If yes, when and what carrier? _____

b. How many employees are currently covered under this plan? _____

Note: John Hancock looks at groups differently that have been solicited LTC insurance previously and therefore may require additional information to further evaluate the group.

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PART 5 – Employer Commitment to Enrollment

The following employer support will be provided. Please note: TX prohibits employer involvement in administration and solicitation.

- Yes No Allow the program to be publicized via company publications, posters, company intranet, e-mail, tent cards, or similar material and activity.
- Yes No Allow eligible employees to attend group meetings during company time.
- Yes No Allow eligible employees to attend individual sessions with the producer during business hours.
- Yes No Secure a favorable introduction for the producer by the officer of the company.
- Yes No Allow employees to payroll deduct premiums. Complete attached List Bill Form.
- Other Please describe _____

PART 6 – Enrollment Period and Marketing

1. The above marketing program and educational activities will commence on _____
2. Application solicitation will start on _____ and will end on _____
(The enrollment period cannot be more than 60 calendar days from the start date of application solicitation.)
3. Please describe your marketing plan in detail. Attach to worksheet.

PART 7 – Benefit Offering

If employer pay, please indicate what the employer is agreeing to pay for.

PLAN A ¹ <input type="checkbox"/>	PLAN B ¹ <input type="checkbox"/>
TIER 1 (CLASS)	TIER 2 (CLASS) IF APPLICABLE
<input type="checkbox"/> Daily Benefit Amount \$_____ (\$50 to \$300) or <input type="checkbox"/> Monthly Benefit Amount \$_____ (\$1,500 to \$9,000)	<input type="checkbox"/> Daily Benefit Amount \$_____ (\$50 to \$300) or <input type="checkbox"/> Monthly Benefit Amount \$_____ (\$1,500 to \$9,000)
Benefit Period: 3 or 5 years	Benefit Period: 3 or 5 years
Elimination Period: 100 days, automatically built in	Elimination Period: 100 days, automatically built in
Inflation: CPI or GPO (where available)	Inflation: CPI or GPO (where available)
Optional Riders: <input type="checkbox"/> SharedCare <input type="checkbox"/> Zero-Day Elimination Period for Home Health Care <input type="checkbox"/> Nonforfeiture	Optional Riders: <input type="checkbox"/> SharedCare <input type="checkbox"/> Zero-Day Elimination Period for Home Health Care <input type="checkbox"/> Nonforfeiture
Payment Type: <input type="checkbox"/> Lifepay <input type="checkbox"/> Paid up at age 65 <input type="checkbox"/> 10-pay	Payment Type: <input type="checkbox"/> Lifepay <input type="checkbox"/> Paid up at age 65 <input type="checkbox"/> 10-pay

1. Benefits, options and availability vary by state. Not all benefits and optional benefits may be available. Please review the state-specific Leading Edge product brochure for details.

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PART 8 – Special Requests

Please indicate any special requests (such as a special effective date for the group) _____

PART 9 – Billing Information

Please complete the attached List Bill Form if payroll deduction/list bill is being requested. (Employer paid cases must be list billed.)

The employer agrees to make payroll deductions as authorized by the employees, and to send the total sum of the premiums to John Hancock, upon receipt of the list bill.

PART 10 – Case Correspondence

1. What is your preferred method of correspondence? E-mail Mail Do not contact
2. How would you like to receive case reporting? On a per-applicant basis On a group basis

A weekly follow-up report will auto generate based upon the method of contact and the type of case reporting you prefer.

PART 11 – Producer and Agency Information

1. Company/agency (MGA/GA) name _____ JH agency code _____
- Producer name _____ JH producer code or SS# _____
- Address _____
- Producer e-mail _____ Phone _____ Fax _____

2. Will more than one producer be assisting with enrollment? Yes No

If yes, provide the following information for each producer:

- a. Company/agency (MGA/GA) name _____ JH agency code _____
- Producer name _____ JH producer code or SS# _____
- Address _____
- Producer e-mail _____ Phone _____ Fax _____

- b. Company/agency (MGA/GA) name _____ JH agency code _____
- Producer name _____ JH producer code or SS# _____
- Address _____
- Producer e-mail _____ Phone _____ Fax _____

3. Is the producer(s) and all those in the commission hierarchy licensed and appointed in all states applicable to this case? Yes No

If no, how do you propose to solicit the business in the states where you are not licensed? _____

4. Is this your initial marketing/sales experience with LTC insurance? Yes No

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PART 12 – Producer and Agency Agreement

Completing this form does not guarantee that coverage will be offered. Official group approval of this worksheet must be obtained prior to the start of marketing activities and application solicitation. A current copy of the employee census is being made available. I certify that the employee census provided is accurate to the best of my knowledge and that those listed as “eligible employees” on the census meet the definition of eligible employee.

I understand that to qualify for the Corporate Solutions Program, the enrollment must meet the minimums established by John Hancock as indicated below.

If John Hancock’s Home Office approves this worksheet and the employer chooses the Corporate Solutions Program as the coverage they want to offer to their employees, the employer will be instructed to sign off on the Corporate Solutions Approval Letter before beginning enrollment.

Name _____ Title _____

Producer signature _____ Date _____

Producer signature _____ Date _____

Producer signature _____ Date _____

Participation Requirements Reminder: In order for this case to qualify for the Corporate Solutions Program selected, John Hancock requires that a minimum of 7 eligible employees (for employer pay) or a minimum of 10 eligible employees (for voluntary pay), requesting simplified underwriting, between the ages of 18-64, must apply and be approved from the eligible employee population.

Minimums must be achieved during the initial open enrollment period.

Home Office Use Only

Approved Declined

Rate class Select Preferred

Average age _____ Average salary _____

Standard Industry Code (SIC) _____

Employer group number _____ Sponsored group number _____

List bill # (if applicable) _____

Initials & approval date _____

If denied, reason _____

Data input into WLTC Client set up? Yes No Initials/date _____

Home office notes _____

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FOR HOME OFFICE USE ONLY

List bill # _____

PART 13 – John Hancock List Bill Request Form

Instructions: Complete and submit this form with the employer worksheet if the employer is paying the premium or offering payroll deduction to the employees. This bill is required on all employer paid cases.

New list bill request Existing list bill, group number _____ (check for informational changes)

Name of list bill group	
Group billing address	
Billing contact	
Phone & fax #	
Number of individuals (Minimum 3 policies)	Number of individuals applying for insurance with John Hancock long-term care _____

Billing mode (Select one)	<input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> ANNUAL Note: All policies must have same mode of payment and list bill notice date.
List bill notice date (Select one)	<input type="checkbox"/> 1st <input type="checkbox"/> 15th <input type="checkbox"/> 28th of each month

General agency	
Agent/contact	
Address	
Telephone & fax #	

Note: A list bill account number will be assigned for your group and you will be notified of your number in the group approval memo. Once a number is assigned to your group, please remember to identify all new business submitted by indicating your list bill group number on each application.

SPECIAL INSTRUCTIONS
