



Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Policy No. (for Internal Use Only)

Medical Exam

- John Hancock Life Insurance Company (U.S.A.)
- John Hancock Variable Life Insurance Company
- John Hancock Life Insurance Company

(hereinafter referred to as *The Company*)

- This form is part of the application for life insurance for the Proposed Life Insured.
- Notice of Disclosure of Information form NB5014 must be used with this Medical Exam if it is being submitted on its own without the main application.
- Print and use black ink. Any changes must be initialed by the Proposed Life Insured.

Proposed Life Insured

1. a) Name First Middle Last b) Date of Birth mmm dd yyyy

c) Social Security/Tax ID Number d) Gender Male Female

Smoking Status

2. Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, a pipe, chewing tobacco, nicotine patches or gum)?
 Yes No If Yes, please provide the following details

| Product | Frequency | Current | Past | Date last used | | |
|------------|--------------|--------------------------|--------------------------|----------------|----|------|
| | | | | mmm | dd | yyyy |
| Cigarettes | pack(s)/ day | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Cigars | x / day | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Other: | x / day | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Family Questions

3. Have any of your immediate family members (parents, brothers and sisters) prior to age 65, died of or been diagnosed as having coronary artery disease, stroke or kidney disease? Yes No
4. Please provide the following details

| Family History | Age | Give Details of Present State of Health | Family History | Age | Cause of Death |
|----------------------------|----------------------|---|----------------------------|----------------------|----------------|
| L I V I N G | Father | | D E C A S E | Father | |
| | Mother | | | Mother | |
| | Brothers and Sisters | | | Brothers and Sisters | |
| | | | | | |

5. a) Name and Address of Personal or Attending Doctor First Middle Last
Street No. & Name, Suite No., City, State, Zip code

b) Telephone No. ()

c) Date last consulted Reason for consultation Diagnosis/Result of visit
mmm dd yyyy

d) List any medications (prescription or nonprescription) you are taking currently

Health Questions - Please complete Details on page 2 for Yes answers.

6. As far as you know, within the last 10 years have you had or been told by a doctor that you had:
- a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or any other disease or disorder of the heart or arteries? Yes No
 - b) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands? Yes No
 - c) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? Yes No
 - d) Arthritis, gout, or any bone, joint, muscle or skin disorder? Yes No
 - e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder? Yes No

Health Questions (continued) - Please complete Details below for Yes answers.

6. **As far as you know, within the last 10 years have you had or been told by a doctor that you had:**
- f) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines? Yes No
 - g) Prostate or testicular disease, disease of the uterus, cervix, ovaries or breasts? Yes No
 - h) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss? Yes No
 - i) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine? Yes No
 - j) Cancer or tumors? Yes No
 - k) An operation or admission to a hospital or any other health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance? Yes No
 - l) Any other health impairment or medically treated condition? Yes No
7. **Within the last 10 years have you:**
- a) used amphetamines, barbiturates, cannabis (marijuana), cocaine, hallucinogens, opiates or any prescription drug except in accordance with physician's instructions? Yes No
 - b) been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use? Yes No
8. **Do you currently**
- a) use alcoholic beverages?
 If **Yes**, describe beverages, Beverages Frequency Quantity
 frequency and quantity
 If **No**, have you ever used alcoholic beverages? Yes No
 If **Yes**, please provide mmm dd yyyy Reason stopped
 date and reason stopped
 - b) have any symptoms or medical concerns which you have not consulted a doctor or any consultation, testing or investigation recommended by a doctor which has not yet been completed? Yes No
9. Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? Yes No

Details for Yes answers to Health Questions - If more space is required, use the Medical Questions Continuation Sheet, NB5034US.

| Question No. | Date | | | Reason and treatment given | Duration of Condition | Name, Address and Telephone Number of Attending Doctor and Hospital |
|--------------|------|----|------|----------------------------|-----------------------|---|
| | mmm | dd | yyyy | | | |
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I, the Proposed Life Insured, authorize:

- John Hancock Life Insurance Company (U.S.A.), John Hancock Variable Life Insurance Company or John Hancock Life Insurance Company (The Company), to obtain an investigative consumer report on me.
- Any physician, medical care provider, hospital, clinic, laboratory, insurance company, the Medical Information Bureau (MIB Inc.), or any other similar person or organization to give The Company and its reinsurers information about me or any minor child who is to be insured.

The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. In turn, The Company is free to disclose such information and any information developed during its evaluation of my application to: (a) its reinsurers; (b) the MIB Inc.; (c) other insurance companies as designated by me; (d) me; (e) any physician designated by me; or (f) any person or entity entitled to receive such information by law or as I may further consent.

I acknowledge receipt of the Notice of Disclosure of Information relating to the underwriting process, investigative consumer reports and the MIB Inc. This authorization will be valid for two years from the date shown. A photocopy of this authorization will be as valid as the original. Information collected under this authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes.

I am entitled, or my authorized representative is entitled, to a copy of this authorization.

Signatures

I have read the statements and answers in this form and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for life insurance for which this medical information was required by The Company.

Signed at City State This Day of Year

Consent for Juvenile Insurance of Parent or Guardian, if other than Owner

Signature of Proposed Life Insured (Parent or Guardian, if under age 15)

- Father Mother Guardian

I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Life Insured.

Signature of Examiner

Name of Agent

Agent's Code

Examiner's Report

Section 1 - Complete for all paramedicals and medical examinations

10. a) Height 11. Blood Pressure Readings 12. Pulse Regu
Did you measure? Yes No 1. 2. 3. Irregu
b) Weight
Did you weigh? Yes No Systolic
c) Any weight change in
the past 12 months? Yes No Diastolic
If Yes, amount of
 Loss Gain

13. Describe general appearance
14. Did anyone accompany the Proposed Life Insured during the examination? If Yes,
please provide details (who it was, relationship to Proposed Life Insured and why present) Yes N
15. Did the Proposed Life Insured understand and answer all the questions
asked in connection with this exam? If No, please provide details Yes N
16. Do you suspect anything unfavorable such as excessive use of
alcohol, cigarettes, or drugs? If Yes, please provide details Yes N

Complete 17-23 if the Proposed Life Insured is age 71 or older .

17. a) Does the Proposed Life Insured drive?
If No, provide details of when and why stopped Yes N
b) Does the Proposed Life Insured do any volunteer work or travel?
If Yes, please provide details Yes N
c) Does the Proposed Life Insured use any assistive devices (cane, walker etc.)
or have any gait or mobility problems? If Yes, please provide details Yes N
d) Does the Proposed Life Insured have a history of falls?
If Yes, please provide details Yes N
e) Does the Proposed Life Insured have any evidence of a cognitive disorder?
(dementia, memory loss, confusion, lack of comprehension, behavioral change?)
If Yes, please provide details Yes N
18. a) Does the Proposed Life Insured need assistance with any of the following activities?
 Bathing Dressing Eating Transferring Toileting
If Yes, please provide details Yes N
b) Does the Proposed Life Insured need assistance with any of the following activities?
 Cooking House Cleaning Laundry Shopping
 Meal Preparation Handling Finances Using the telephone Taking Medication
If Yes, please provide details Yes N

19. Delayed Word Recall - Point to three objects and ask the Proposed Life Insured to tell you what they are.
Advise the Proposed Life Insured that you will be asking him/her to recall the words in a few minutes.
Record the 3 objects: 1 2 3
c) Does the Proposed Life Insured use any assistive devices (cane, walker etc.)
or have any gait or mobility problems? If Yes, please provide details Yes N
d) Does the Proposed Life Insured have a history of falls? Yes N

22. Please record how long it takes for the Proposed Life Insured to complete the following task.
Get up from seated position, walk 10 feet, return and sit again. Time: seconds (for entire process)

23. Please have the Proposed Life Insured draw a clock reading 11:10.
If more space is required for the drawing, please attach a separate page.

Section 2 - Complete only for medical examinations.

24. On examination is/are there any:

- a) Extra or abnormal heart sounds? Yes No
 c) Cardiomegaly or cardiac enlargement? Yes No
 If Yes, provide Details below.

- b) Murmurs? Yes No
 d) Inadequate circulation anywhere? Yes No
 (e.g. shortness of breath, edema, stasis dermatitis, PVD)

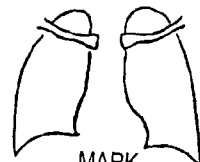
Please complete the following heart chart if any YES answers to question 24, if there is any pulse irregularity, if any blood pressure reading over 150/100 or a history of hypertension or heart disease.

Murmur If more than one, describe in Details below.

None Systolic Diastolic Grade I II III IV V VI Loud Harsh Rough Soft Blowing

- Signs of Failure** Shortness of breath? Yes No
 Cyanosis? Yes No
 Engorgement of neck veins? Yes No
 Swelling of ankles? Yes No
 Rales at lung bases? Yes No

Location



Area of Murmur by —XXXX
 Transmission by —————>

- Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

25. On examination, is there any abnormality of:

- a) Respiratory system?
 b) Abdomen (visceral organs, size of liver and spleen, palpable mass, evidence of surgery)?
 c) Eyes, ears, nose, mouth, pharynx, head and neck (incl. hearing, vision, optic fundi, speech, thyroid)?
 d) Skin, lymph nodes, peripheral arteries or veins?
 e) Nervous system (incl. reflexes, weakness, gait, paralysis, tremors)?
 f) Genitourinary system (incl. prostate, rectum (only if male), external genitalia)?
 g) Breasts?
 h) Musculoskeletal system (incl. spine, joints, amputation, deformity)?

26. Have you examined the Proposed Life Insured in the past year?

27. Is the Proposed Life Insured your private patient?
 If Yes, please provide details of any medical history which is pertinent to the mortality risk and not already disclosed.

Details for Yes answers to questions 25 - 26 - If more space is required, use the Medical Questions Continuation Sheet, NB5034US.

| Question No. | Date | | | Reason and treatment given | Duration of Condition | Name, Address and Telephone Number of Attending Doctor and Hospital |
|--------------|------|----|------|----------------------------|-----------------------|---|
| | mmm | dd | yyyy | | | |
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Examiner's Report

How did you identify the Proposed Life Insured? Driver's License (with photo) Other photo ID

Examination location Examiner's Office Proposed Life Insured's home Proposed Life Insured's place of business

Indicate requirements completed Blood Urine EKG TST

Ticket number _____ Date sent to lab (mmm dd yyyy) _____ Date sent to home office (mmm dd yyyy) _____

Indicate any requirements not completed and reason _____

I hereby certify that I have personally examined the Proposed Life Insured and have correctly and fully reported my findings.

Signed at City _____ State _____ This _____ Day of _____ Year _____

Name of Examiner _____
 MD RN
 DO RPN/LPN

Company APPS EMSI Exam One Portamedic Superior Mobile Medics
 Other: _____

City, State _____ Telephone No. _____

Signature of Examiner _____

Examination completed on (date and time) (mmm dd yyyy) _____ Time _____



Service Office:
200 BLOOR STREET EAST
TORONTO, ONTARIO
CANADA M4W 1E5

Notice of Disclosure of Information

- John Hancock Life Insurance Company (U.S.A.)
- John Hancock Variable Life Insurance Company
- John Hancock Life Insurance Company
(hereinafter referred to as *The Company*)

Proposed Life Insured

| Name | First | Middle | Last |
|------|-------|--------|------|
| | | | |

Information Exchange

This brief description of our underwriting process is designed to help you understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others, and your right to learn the nature and substance of that information upon written request.

The purpose of the underwriting process is to make sure that you qualify for life insurance and if so, to establish the proper premium charge for that insurance. The information necessary to evaluate your application is dependent upon your age, the amount of insurance you are applying for, your medical history, your occupation, your avocations and other personal information. Your answers on the application are the principal source of information; however, additional sources of information may be required.

Information you provide will be treated as confidential. The Company may, however, make a brief report thereon to the Medical Information Bureau (MIB Inc.), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, MIB Inc. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act.

The address of the Bureau's Information Office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112; telephone number (617) 426-3660.

The Company may also release information given in your application and information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Investigative Consumer Report Notice

As part of our normal procedure, an investigative consumer report may be prepared concerning your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. This information will be obtained through personal interviews with your friends, neighbors and associates.

On request to the Chief Underwriter, at the above Service Office address, we will disclose to you whether or not an investigative consumer report was done.

If an investigative consumer report was done, we will also disclose to you the nature and scope of the report, a summary of consumer rights and the name and address of the consumer reporting firm from whom you may request a copy of the report.

Insurance Information Practices

The personal information we obtain about you is confidential and we will not disclose it to other parties without your written authorization except as permitted or required by law. You have the right to access the personal information about you that appears in our files, including any medical record information disclosed within three years of your request, unless that information relates to a claim or a civil or criminal proceeding.

However, we will normally give medical record information only to a licensed physician of your choice. You also have the right to seek correction of information about you that you believe to be inaccurate or incomplete. We will provide you with a more detailed explanation of our information practices and access and correction procedures if you send us a written request. You may do so by writing to the Chief Underwriter at the above Service Office address.

Please give this page to the Proposed Life Insured.



John Hancock Life Insurance Company
John Hancock Variable Life Insurance Company
John Hancock Place
Boston, Massachusetts 02117

**NOTICE AND CONSENT FOR ORAL FLUID, URINE, OR BLOOD TESTING
WHICH WILL INCLUDE AIDS VIRUS (HIV) ANTIBODY/ANTIGEN TESTING
APPLICATION FOR LIFE INSURANCE**

To determine your insurability, John Hancock has requested that you provide a sample of your oral fluid, urine, or blood for testing and analysis. All tests will be performed by a licensed laboratory.

The consent you give by signing this form authorizes the insurer to withdraw oral fluid, urine, or blood and order laboratory tests only in regard to your present application for life insurance.

The test or tests to be performed are used to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable.

TESTS TO BE PERFORMED

We will use an ELISA test or a Western Blot Assay, or both.

An ELISA test is an enzyme-linked immunosorbent assay serologic test which has been licensed by the Federal Food and Drug Administration to detect antibodies to the human immunodeficiency virus. A positive ELISA test means an ELISA test performed in accordance with the manufacturer's specifications which is reactive on an initial testing and on at least one of two additional tests of the same specimen.

A Western Blot Assay is an assay which uses reagents consisting of HIV antigens separated by polyacrylamide-gel electrophoresis and then transferred to nitro-cellulose paper to detect antibodies to the human immunodeficiency virus. A reactive Western Blot Assay is a Western Blot Assay which is reactive according to To determine your insurability, John Hancock has requested that you provide a sample of your oral fluid, urine, approved product circular for the Western Blot Assay reagents and laboratory apparatus.

MEANING OF POSITIVE TEST RESULT

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test/screening results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

CONFIDENTIALITY OF TEST RESULTS

All test results will be treated confidentially. They will be reported by the laboratory to John Hancock. When necessary for business reasons in connection with insurance you have or have applied for with John Hancock, John Hancock may disclose test results to others involved solely in the underwriting process such as its affiliates, reinsurers, employees or contractors. As a member of the Medical Information Bureau (MIB, Inc.), if the test results for HIV antibodies/antigens are other than normal, John Hancock will report to the MIB, Inc., a generic code which signifies only a non-specific blood, oral fluid (saliva), or urine test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

COST OF TESTING

The cost of any testing will be borne by John Hancock.

NOTIFICATION OF TEST RESULTS

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, John Hancock will contact your designated physician, or you if you have not designated a physician, John Hancock will ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

TIME LIMIT

This Consent shall be valid for a period of 30 months from the date noted below.

CONSENT

I have read and I understand this Notice of Consent for Oral Fluid, Urine, or Blood Testing Which Will Include HIV Antibody/Antigen Testing. I voluntarily consent to the withdrawal of oral fluid, urine, or blood from me, the testing of that oral fluid, urine, or blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Name of Proposed Insured

Date of Birth

Name and Address of Designated Physician: _____

Signature of Proposed Insured or
Parent/Guardian

Date

State of Residence

For Agency/Firm Use Only:

Agency/Firm

Marketing Rep./Agency #

HIV INFORMATION

HIV is the virus that causes AIDS. AIDS is a condition of acquired immunological deficiency that is associated with infection of the cells of the immune system. Infection occurs when viral information from HIV becomes permanently incorporated into host cell DNA. Six commonly acquired illnesses resulting from the contraction of the HIV virus are seroconversion illness, seroconversion, asymptomatic HIV infection, persistent generalized lymphadenopathy (PGL), symptomatic HIV infection, and acquired immunodeficiency syndrome (AIDS).

- Seroconversion illness, also known as the acute HIV syndrome occurs in about 20% of HIV-infected persons. Symptoms of seroconversion illness include fever, sweats, discomfort, muscle and joint pain, headaches, diarrhea, and rash.
- Seroconversion is the development of detectable levels of HIV antibodies. Within six months of infection, 99% of HIV-infected person will seroconvert.
- Asymptomatic HIV infection means infected persons have no obvious symptoms but usually experience low-grade fevers, headaches, and fatigue.
- PGL is defined as two or more enlarged lymphnodes which persist for more than three months.
- Symptomatic HIV infection occurs when the infected person develops clear symptoms of immune deficiency which are not severe enough for a diagnosis of AIDS. Symptoms include fatigue, night sweats, diarrhea, fever, localized infections with candida, herpes simplex and varicellazoster, and oral hairy leukoplakia.
- AIDS is the end stage of HIV infection. It is a progressive, debilitating condition characterized by major defects in the immune system. The immune suppression allows the expression of opportunistic diseases, including infections and cancers.

AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next 10 years.

HOW HIV IS SPREAD AND GROUPS AT RISK FOR CONTRACTING HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing.

Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

HOW A PERSON BECOMES INFECTED WITH HIV

The virus is most commonly spread through sexual contact (vaginal, anal, or oral sex) and by sharing needles or works to shoot injectable drugs. An infected mother may infect her baby during pregnancy, at the time of birth, or while breast feeding. Very rarely, contact with blood through open cuts or wounds, or splashes to the eyes, may also spread the virus. You cannot get infected with the virus by donating or giving blood, or through casual contact.

HOW CAN I KEEP FROM GETTING OR SPREADING THE VIRUS?

Know your sex partners. Ask questions about past sexual history and drug use. Be honest about your own past.

Practice "safer sex": use condoms for vaginal, anal, and oral sex; don't allow your partner's blood, semen, urine or feces to get in your vagina, anus, or mouth; don't allow your semen, blood, urine, or feces to get in your partner's vagina, anus, or mouth; don't share sex toys. Remember that condoms do not provide 100% protection against infection, and that anal intercourse (even with a condom) is more risky than oral or vaginal intercourse.

Don't use *injection* drugs, but if you do, never share needles or syringes with anyone.

See your doctor at least one a year.

Don't share razors, toothbrushes, or anything else that could be contaminated with blood or body fluids.

WHAT A PERSON CAN DO WHOSE TEST RESULTS ARE POSITIVE OR NEGATIVE

If you test negative, the test indicates either that you are not infected, or possibly, that you were infected very recently (within the past 3-6 months). You can learn through counseling how to protect yourself from infection in the future. If you have recently practiced risky behavior, you may want to be retested.

If you test positive, the test indicates that you have been infected with HIV. You can still take action to benefit your health and reduce the chance of infecting others. This includes maintaining a good state of physical and mental health. By doing so, you may delay the development of AIDS. It is suggested that you:

- Seek medical treatment immediately. Many drugs are now available for treatment of persons infected with HIV even if symptoms are not present. Early treatment is usually beneficial to many people with HIV.
- Receive all recommended vaccines. Discuss with your physician which vaccines are recommended and which should be avoided.
- Maintain good nutrition, exercise and get adequate rest.
- Receive emotional support and work on managing stress.
- Eliminate recreational drugs, or at least reduce alcohol, and smoking.
- Stop injecting drugs. If you continue to inject, stop sharing equipment, and use a new syringe and needle each time. At the very least, you should learn to clean your needles or works with full-strength bleach and water.
- Don't have vaginal, anal, oral or other sexual contact that exposes other to your semen, vaginal secretions or blood. Avoid exposing others and getting sexually transmitted diseases (through abstinence or by always using latex or polyurethane condoms or barriers).
- Inform all known sexual or needle-sharing partners, including any new partners, about your infection.
- Do not donate blood or organs (change designation on driver's license).
- Seek counseling regarding becoming pregnant or fathering a child.
- If you are pregnant and planning to continue that pregnancy, discuss with your physician treatments that may protect your baby.

COUNSELING RESOURCES LIST

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to John Hancock. Therefore, John Hancock makes no representations or warranties that this information is accurate as of the date you receive this list. Also, John Hancock makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

AIDS HOTLINE-U.S. PUBLIC HEALTH SERVICE
(800) 342-AIDS

SPANISH AIDS HOTLINE
(800) 222-SIDA

TTY INFORMATION
Information and Referral for Hearing Impaired
(213) 464-0029

KERN COUNTY AIDS TEAM - Bakersfield
(805) 861-3631

CENTRAL VALLEY AIDS TEAM - Fresno
(209) 264-2436

AIDS PROJECT - LOS ANGELES - West Hollywood
(213) 876-8951

SHASTA COUNTY HELPLINE
(916) 225-5252

AIDS PROJECT - EAST BAY - Oakland
(415) 420-8181

SACRAMENTO AIDS FOUNDATION-Sacramento
(916) 448-2437

SAN FRANCISCO AIDS FOUNDATION
San Francisco
(415) 846-5855

SANTA CLARA COUNTY ARIS PROJECT
Campbell
(408) 370-3272

SONOMA COUNTY AIDS INFORMATION HOTLINE
(707) 579-AIDS

AIDS HOTLINE - SOUTHERN CALIFORNIA
(800) 922-AIDS

AIDS SERVICES FOUNDATION OF ORANGE
COUNTY - Costa Mesa
(714) 646-0411

HEMOPHILIA FOUNDATION OF SOUTHERN CAL
Social Services - Southern California
Hemophilia AIDS Information
(818) 792-6192
(714) 740-2222

CALIFORNIA DEPT. OF HEALTH SERVICES
Statewide Services - Office of AIDS - Sacramento
(916) 323-7415

INLAND AIDS PROJECT
Riverside/San Bernardino Counties
(714) 784-2437

SAN DIEGO AIDS PROJECT
(619) 543-0300 - City of San Diego
(619) 945-6000 - City of Vista

SANTA BARBARA COUNTY AIDS HOTLINE
(805) 965-2925