

**GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE**

To be filled out personally by the applicant(s)

PLEASE PRINT IN BLACK INK

Do not separate application pages

APPLICANT(S) INFORMATION (Only list persons applying for coverage)

Name (Last, First, M.I.)	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
1. Primary (You)	<input type="checkbox"/> M <input type="checkbox"/> S						
2. Spouse							
3. Dependent Children							
Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.							
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)

Street (Include Apt.) _____ City _____ State _____ ZIP _____

5. Phone Numbers: () _____ () _____ Home Other Best number and times to call E-mail Address _____

6. Payor (If not You): Name _____ Street _____ City _____ State _____ ZIP _____

7. Your Beneficiary: Name _____ Relationship _____ Age _____ You will be the beneficiary for your spouse.

8. Your Occupation: _____ Date Hired: _____ 9. Total Annual Household Income: \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
Prior Employment (If within 2 years): _____ Household Income: \$15,001 to \$35,000 \$50,001 to \$75,000 \$100,000 or more

10. Primary Applicant's Mother's Maiden Name: _____ Spouse's Mother's Maiden Name: _____
(Last Name Only) (Last Name Only)



COVERAGE INFORMATION

11. Requested Health Class: Primary: Preferred Stand. I Stand. II
 Spouse: Preferred Stand. I Stand. II
 Tobacco Use: Primary Yes No Spouse Yes No Child a. Yes No Child b. Yes No Child c. Yes No Child d. Yes No Child e. Yes No
 (See Question 30 for applicants age 18 and older, including dependent children)

Requested Effective Date: ____/____/____
 Plan includes Preferred Network; if not wanted, check here
 Network: _____
 Special Instructions: _____

Copay Plans	<input type="checkbox"/> Copay Select SM <input type="checkbox"/> \$ 500 <input type="checkbox"/> \$2,500	HSA Plans	Single 2008	Family 2008	Plan 80, Plan 100, and Saver 80	<input type="checkbox"/> Saver 80 SM <input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> Copay Saver SM <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000		<input type="checkbox"/> HSA 100 [®] <input type="checkbox"/> \$1,100 <input type="checkbox"/> \$2,200	<input type="checkbox"/> Plan 80 SM <input type="checkbox"/> \$1,000 (Saver 80 only)		
Optional	<input type="checkbox"/> Supplemental Accident <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	Optional	<input type="checkbox"/> HSA <input type="checkbox"/> \$1,900 <input type="checkbox"/> \$3,850	<input type="checkbox"/> Plan 100 [®] <input type="checkbox"/> \$1,500	Optional	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$2,500
	<input type="checkbox"/> Preventive Care (Copay Saver only)		<input type="checkbox"/> HSA Saver [®] <input type="checkbox"/> \$2,900 <input type="checkbox"/> \$5,800	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$3,500		
Optional	<input type="checkbox"/> 2 Additional Dr. Visits a Year (Copay Saver only)	Optional	<input type="checkbox"/> Hospital Indemnity Rider (Not Available with \$1,100 or \$2,200 deductible)	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$5,000	Optional	<input type="checkbox"/> Supplemental Accident <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
	<input type="checkbox"/> Prescription Drug-no annual max. (Copay Select only)		<input type="checkbox"/> Lifetime Maximum-\$5 Million	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$7,500		<input type="checkbox"/> Preventive Care
Optional	<input type="checkbox"/> Substance Abuse Benefit	Optional	<input type="checkbox"/> Lifetime Maximum-\$5 Million	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$10,000	Optional	<input type="checkbox"/> Prescription Drug Card (Not with Saver 80)
			<input type="checkbox"/> Substance Abuse Benefit	<input type="checkbox"/> Saver 80 only <input type="checkbox"/> \$5,000		<input type="checkbox"/> Lifetime Maximum-\$5 Million

BILLING (or attach health insurance quote)

12. Initial Payment With Application: Check EFT Credit Card (authorization on page 6)
 Ongoing Payments: Monthly (EFT) List Bill (include forms) Quarterly Direct Bill

Base Premium Amount	+ _____			
Supplemental Accident	+ _____	Optional		
Preventive Care	+ _____	Optional		
2 Additional Dr. Visits a Year	+ _____	Optional		
Prescription Drug - no annual max.	+ _____	Optional		
Prescription Drug Card	+ _____	Optional		
Lifetime Maximum - \$5 Million	+ _____	Optional		
Substance Abuse Benefit	+ _____	Optional		
HSA Deposit	+ _____	\$25 Monthly Minimum (only with HSA)		
Child(ren) Admin. Fee	+ _____	\$5 per month (only if primary applicant <18 yrs)		
Total Monthly Payment	= \$ _____	→ If Quarterly →	X3 = \$ _____	Total Quarterly Payment
One-Time HSA Set-Up Fee	+ _____	\$10 only with HSA	+ _____	One-Time HSA Set-Up Fee
One-Time HSA Indemnity Rider	+ _____		+ _____	One-Time HSA Indemnity Rider
Initial Payment	= \$ _____	Make check payable to "Golden Rule."	= \$ _____	Initial Payment

OTHER COVERAGE

13. Within the last 62 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below. Yes No
 Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (7) above the signature lines).

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

14. Will the term life benefit replace any existing life insurance? Company Name _____ Policy # _____ Yes No N/A

15. Has any applicant ever had an application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) _____ Yes No
 Person: _____ Company: _____ Action Taken: _____
 Date: _____ Reason for Action: _____

16. Has any applicant previously applied for, or been covered by, Golden Rule? _____ Yes No
 If yes, who? _____ Policy/Certificate # _____

BROKER STATEMENT: Review the completed application before signing below

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

I agree with the answer given for Question 14: "Will the term life benefit replace any existing life insurance?" (If the response for Question 14 does not reflect your understanding, please check this box and attach an explanation.)

X _____
Signature of Licensed Broker

X Philip J. Randazzo
Print Full Name

1030582
Broker Number

HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide insurance for employees.

I certify that:

- (a) I am not employed by an employer with 2-50 employees; or
- (b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance. 953B-799

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company,

government agency, consumer-reporting agency, or the Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

Golden Rule may also release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X _____ at _____
Date City State
X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)
X _____
Signature of Spouse (If to be covered)

AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health-care provider, consumer-reporting agency, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule;
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices;
- Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X _____ at _____
Date City State
X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)
X _____
Signature of Spouse (If to be covered)

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with OptumHealth Bank)

By signing to the right, I acknowledge that:

- I wish to establish an HSA with OptumHealth Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or OptumHealth Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify OptumHealth Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request OptumHealth Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize OptumHealth Bank to share information about my HSA with the authorized user named and to allow withdrawals by check, debit card, or other means to be made by such authorized user.
- I certify that the information provided in this application is true and complete.

X _____

Signature of Primary Applicant

Primary Applicant's

Social Security Number

Spouse's

Social Security Number

Per the USA Patriot Act: To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User's _____

First Name

Middle Initial

Authorized User's _____

Last Name

Authorized User's _____

Date of Birth

Authorized User's _____

Social Security No.

155X-010

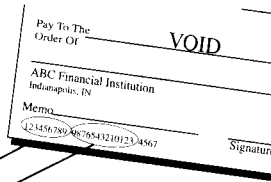
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION -- ONLY IF PAYING BY EFT

I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Nine-digit Check Routing No. _____

Checking Account No. _____



Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____

Day

Date Signed

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X _____

Signature of Account Holder

E-mail Address _____

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize Golden Rule to bill my MasterCard/Visa account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Name as Printed on Card: _____

Billing Address _____

City _____

State _____

ZIP _____

Type of Card: MasterCard Visa Expiration Date: _____

Month

Year

Card Number: _____

X _____

Signature of Authorized User

REVIEW BEFORE MAILING THE APPLICATION

- Please read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if any family member is currently pregnant.
- Coverage is not available if the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- You will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.

- There is no coverage until approved in writing by Golden Rule.
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

Mail this Application Packet with the following:

- Health insurance quote.
- Initial payment:
 - Check made payable to "Golden Rule";
 - EFT authorization (if paying via EFT); or
 - Credit card authorization (if paying via credit card).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
PO Box 68994
Indianapolis, Indiana 46268-0994

This form must be signed and returned to GOLDEN RULE INSURANCE COMPANY with all applications.

NEVADA PORTABILITY CERTIFICATION

INSTRUCTIONS (You may be eligible for a portability plan -- guarantee issue without preexisting conditions limits.)

PART I Review the statements and sign where appropriate.

PART II, PART III Review and complete only if you sign under B. in Part I.

PART I ELIGIBILITY INFORMATION (Decide whether or not all of the statements 1-6 apply to you.)

1. I do not have any other health insurance coverage.
2. I have been insured by *creditable coverage*¹ (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under or offered in connection with a *group health plan*² (as defined below), a governmental plan, a church plan, or a basic or standard health benefit plan that was not renewed because the carrier discontinued offering and renewing individual health benefit plans in Nevada.
4. My most recent coverage was not terminated due to nonpayment of premiums or fraud.
5. I am not eligible for any coverage under a *group health plan*² (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me -- or -- I was not offered group continuation of coverage (including COBRA).

Carefully review the statements above and sign below where appropriate.

A. One or more of the six statements above **do not** apply to **all** applicants listed on this application.

Signature _____ Date _____

If you signed under A, STOP here.

-- OR --

B. I represent that all six of the statements above **do** apply to the applicants listed.

Applicants for whom all statements do apply: _____

Signature _____ Date _____

PART II PLAN DESIGN, PRICE, AND AVAILABILITY

At this time, we are offering the Guarantee Issue Individual Basic and Standard portability plans through our affiliate – PacifiCare Life Assurance Company, a UnitedHealthcare Company. To apply for one of these plans and to obtain details on plan design and price, please contact your broker or call (800) 232-5432 for assistance.

What if only one or two family members want to apply for a portability plan and the others want to be underwritten for a plan without portability rights?

Complete two separate applications, and we will consider the family members under two separate plans. Children are not required to apply with their parent, but may apply separately.

PART III You must sign and date below if you signed under B. in Part I.

Not Applying for a Guarantee Issue Individual Basic and Standard Portability Plan

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time. I understand I must apply to PacifiCare Life Assurance Company if I want to apply for a portability plan.

I realize if I am eligible and I do not apply for a portability plan within 63 days of losing my prior coverage, this right may no longer be available to me.

X _____
Signature of Proposed Insured

X _____
Date

¹ *Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

² Generally, a *group health plan* is any coverage existing in connection with employment. Included are employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.

DRIVING -- FOR ALL APPLICANTS

17. In the last 24 months, has any applicant participated in driving any type of motorcycle? Yes
If yes, please answer the following questions:
 a. Which applicant(s)? Primary Spouse Child a. Child b. Child c. Child d. Child e.
 b. Does applicant have a valid motorcycle license? Yes Yes Yes Yes Yes Yes Yes
 c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked?
 d. Within the last 24 months, has the applicant, while operating any motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details."

MEDICAL HISTORY -- FOR ALL APPLICANTS

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? | <input type="checkbox"/> | <input type="checkbox"/> | 24. In the last 10 years, has any applicant: | | |
| 19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language? | <input type="checkbox"/> | <input type="checkbox"/> | a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. In the last 6 months , has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | c. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Within the last 10 years, has any applicant had any diagnosis or treatment of any disease or disorder of the: | | | 25. In the last 10 years, has any applicant had any diagnosis or treatment of any disease, disorder, or abnormality of the: | | |
| a. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | a. heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | d. muscular or skeletal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. In the last 10 years, has any applicant had any diagnosis or treatment of: | | | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 26. In the last 10 years, has any applicant had any diagnosis or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | 28. In the last 5 years, has any applicant had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, show who and how many drinks per week in "Medical History Details" (one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor). | | |
| g. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | 31. List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details. | | |
| i. cancer? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| j. diabetes or sugar in the blood or urine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| k. stroke? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| l. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| m. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| n. mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

