MEDICAL BENEFITS CLASS ACTION SETTLEMENT
MEDICAL INFORMATION FORM

All information relating to you that is disclosed to or obtained by the CLAIMS ADMINISTRATOR, BP, healthcare providers, or any other authorized entity in connection with exercise of a BACK-END LITIGATION OPTION may be used only by: (i) you, upon request; (ii) BP defendants in a BACK-END LITIGATION OPTION mediation or a BACK-END LITIGATION OPTION LAWSUIT; (iii) the mediator of your BACK-END LITIGATION OPTION MEDIATION; or (iv) the CLAIMS ADMINISTRATOR, healthcare providers, or any other authorized entity to the extent necessary for the administration of this MEDICAL SETTLEMENT AGREEMENT according to its terms, including your exercise of the BACK-END LITIGATION OPTION.

You are receiving this form because you submitted a NOTICE OF INTENT TO SUE and a BP defendant has elected to mediate your claim. You must submit this completed form to the CLAIMS ADMINISTRATOR within 60 days of the CLAIMS ADMINISTRATOR sending you the NOTICE OF MEDIATION.

This form must be signed personally by the person whose information is being requested, or in the case of a person who is (1) a minor, (2) lacking capacity or is incompetent, or (3) deceased, by his or her AUTHORIZED REPRESENTATIVE. If you are an AUTHORIZED REPRESENTATIVE, please provide the information requested for the person for whom you are asserting a claim, and also submit Appendix A.

Print or type all responses. Attach additional sheets if needed. In completing this form, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you are represented by counsel, you may and should consult with your attorney if you have any questions regarding the completion of this form. Your lawyer may submit this form for you, but may not sign it for you.

The capitalized terms in this form are defined in the MEDICAL SETTLEMENT AGREEMENT, which is available at www.deepwaterhorizonmedicalsettlement.com or by calling toll free 1-877-545-5111.

You should submit all your materials together. You should retain a copy of anything submitted to the CLAIMS ADMINISTRATOR.

I. Personal & Background Information (update information if it has changed since you submitted your NOTICE OF INTENT TO SUE)

Claimant ID Number

First Name M.I. Last Name

Complete the remaining items only if your information has changed since you submitted your NOTICE OF INTENT TO SUE.

Any Other Names Used in the Last 10 Years

Current or Last Known Street Address

City State Zip Code

Telephone Number (Daytime) - - Telephone Number (Evening) - -

Cellular Number - - Fax Number - -

E-mail Address (if any)

Date of Birth (mm/dd/yyyy) / / Social Security Number - -

Driver's License Number / Other State ID State Gender ☐ Male ☐ Female

II. Representation by Legal Counsel

Are you represented by any lawyer in connection with this claim?

☐ Yes ☐ No

If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your claim will be made to your lawyer):

Lawyer's First Name M.I. Lawyer's Last Name

Law Firm's Name

Section continues on next page

Law Firm's Street Address

City State Zip Code

Telephone Number - - Fax Number - -

Lawyer's E-mail Address

III. Background Information

A. Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If married, name of spouse: _____ Date of marriage: _____ / _____ / _____

B. Do you have children?

☐ Yes ☐ No

If "yes," please provide name(s) and date(s) of birth:

_____

_____

_____

C. Residence History: Please complete the following information regarding your residences for the past 20 years.

Street address	City	State	Zip code	Date moved in	Date moved out

Section continues on next page

1. To the best of your knowledge, did you ever reside within 1 mile of any of the following?

Factory/plant	☐ Yes	☐ No	What kind: _____
Refinery	☐ Yes	☐ No	
Superfund site	☐ Yes	☐ No	

2. Did you live in a mobile home provided as a result of Hurricane Katrina?

☐ Yes ☐ No

If "yes," how long did you live in the mobile home? _____

3. Have you lived in a residence with any mold problems?

☐ Yes ☐ No

If "yes," how long did you live in the residence? _____

4. Have you filed any claim for mold-related problems?

☐ Yes ☐ No

5. Have you lived in a residence with any Chinese drywall?

☐ Yes ☐ No

If "yes," how long did you live in the residence? _____
Have you filed a claim for Chinese drywall?

☐ Yes ☐ No

6. Have you lived in a residence with asbestos insulation, pipe covering, or decorative ceiling?

☐ Yes ☐ No

If "yes," how long did you live in the residence? _____

7. How many hours a day do you estimate that you spend in an automobile? _____

D.1. **Employment History**: Please complete the following information regarding all employers that you have had in the last 20 years. If necessary, please provide the information for additional employers on additional pages.

Name of Employer: _____

Address of Employer: _____

Job Title: _____

section continues on next page

Job Duties: _____

Date(s) of Employment: _____

2. Have you ever worked in one of the following occupations, and if so, for how many years?

	Occupation	Length of Employment		Occupation	Length of Employment
☐	Auto repair		☐	Dry cleaning	
☐	Garage worker		☐	Electronics	
☐	Brake lining		☐	Firefighter	
☐	Assembly/machine operator		☐	Hairdressing/ cosmetology	
☐	Coal miner		☐	Farming	
☐	Carpentry		☐	Textile worker	
☐	Chemist		☐	Arborist	
☐	Cook/chef		☐	Fishing	
☐	Janitor		☐	Mining	
☐	Chemical industry		☐	Highway repair	
☐	Construction		☐	Pipefitter	
☐	Painter		☐	Sandblaster	
☐	Lumber/sawmill		☐	Gasoline station	
☐	Welder		☐	Railroad/train yard	
☐	Trucking		☐	Rubber industry	
☐	Metal Refining		☐	Boating industry	
☐	Petroleum industry		☐	Utility worker	
☐	Pulp/paper production		☐	Photography/ photo developer	
☐	Plumbing		☐	Power lineman	
☐	Teaching		☐	Commercial fishing	
☐	Vapor degreasing		☐	Foundry	
☐	Laboratory work		☐	Shipyard	
☐	Funeral director/ embalmer		☐	Pest control/ exterminating	
☐	Nursing		☐	Airplane pilot	
☐	Tankers/seaman		☐	Flight attendant	
☐	Woodworking		☐	Butcher	
☐	Slaughterhouse or abattoir		☐	Clinical/science laboratory	
☐	Nuclear power plant		☐	Veterinary practitioner	

3. Have you ever been in contact with or worked at a job handling any of the following materials?

Aerosols	☐	Yes	☐	No	☐ Not sure
Acid mists	☐	Yes	☐	No	☐ Not sure
Acrylamide	☐	Yes	☐	No	☐ Not sure
Agent Orange	☐	Yes	☐	No	☐ Not sure
Aldrin	☐	Yes	☐	No	☐ Not sure
Anesthetic gases	☐	Yes	☐	No	☐ Not sure
Arsenic	☐	Yes	☐	No	☐ Not sure
Asbestos	☐	Yes	☐	No	☐ Not sure
Asphalt and tar	☐	Yes	☐	No	☐ Not sure
Benzene	☐	Yes	☐	No	☐ Not sure
Beryllium	☐	Yes	☐	No	☐ Not sure
Cadmium	☐	Yes	☐	No	☐ Not sure
Carbon black	☐	Yes	☐	No	☐ Not sure
Chlordane	☐	Yes	☐	No	☐ Not sure
Chromium	☐	Yes	☐	No	☐ Not sure
Coal	☐	Yes	☐	No	☐ Not sure
Coal tar	☐	Yes	☐	No	☐ Not sure
Crude oil	☐	Yes	☐	No	☐ Not sure
Cotton	☐	Yes	☐	No	☐ Not sure
Creosote	☐	Yes	☐	No	☐ Not sure
Crop dust and sprays	☐	Yes	☐	No	☐ Not sure
DDT	☐	Yes	☐	No	☐ Not sure
Degreasing agents	☐	Yes	☐	No	☐ Not sure
Dieldrin	☐	Yes	☐	No	☐ Not sure
Diesel	☐	Yes	☐	No	☐ Not sure
Engine exhaust	☐	Yes	☐	No	☐ Not sure
Dioxin (TCDD)	☐	Yes	☐	No	☐ Not sure
Dyes or stains	☐	Yes	☐	No	☐ Not sure
Formaldehyde	☐	Yes	☐	No	☐ Not sure
Fiberglass	☐	Yes	☐	No	☐ Not sure
Gasoline	☐	Yes	☐	No	☐ Not sure
Insulation	☐	Yes	☐	No	☐ Not sure
Lead	☐	Yes	☐	No	☐ Not sure

section continues on next page

Mercury	☐	Yes	☐	No	☐	Not sure
Nickel	☐	Yes	☐	No	☐	Not sure
Paints	☐	Yes	☐	No	☐	Not sure
Pentachlorophenol	☐	Yes	☐	No	☐	Not sure
PCBs	☐	Yes	☐	No	☐	Not sure
Pesticides or fungicides	☐	Yes	☐	No	☐	Not sure
Phenol	☐	Yes	☐	No	☐	Not sure
Plastics	☐	Yes	☐	No	☐	Not sure
Silica	☐	Yes	☐	No	☐	Not sure
Solvents	☐	Yes	☐	No	☐	Not sure
Soots or tars	☐	Yes	☐	No	☐	Not sure
Mineral oils	☐	Yes	☐	No	☐	Not sure
TCE	☐	Yes	☐	No	☐	Not sure
Toluene diisocyanate	☐	Yes	☐	No	☐	Not sure
Vinyl chloride	☐	Yes	☐	No	☐	Not sure
Welding fumes	☐	Yes	☐	No	☐	Not sure
Wood dust/sawdust	☐	Yes	☐	No	☐	Not sure
X-rays	☐	Yes	☐	No	☐	Not sure
Radioactive materials	☐	Yes	☐	No	☐	Not sure

E. Education History: Please provide the following information about your education.

If you attended school beyond high school, please complete the following for each school that you attended after high school. If necessary, please provide the requested information for additional schools on additional pages.

Name of School	City, State	Dates of Attendance

F. Have you had any health insurance provided either through company employment (self, spouse, or parent), self-purchase of insurance or through governmental health agency (Medicare, state plan) to you and/or paid medical bills on your behalf from January 1, 2000 through the present?

☐ Yes ☐ No

If "yes," please complete the following:

Name of insurance provider	**Address**

section continues on next page

G. Have you applied for worker's compensation, social security, or state or federal disability benefits in the past?

☐ Yes ☐ No

If "yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as you can. If necessary, please provide the requested information for additional claims on additional pages.

1. Date (or year) of application: _____
2. Type of benefits: _____
3. Amount awarded: _____
4. Basis of your claim: _____
5. If denied, reason for denial: _____
6. Location claim was filed: _____
7. To what agency or company you submitted your application: _____

H. Have you made any claim related to Hurricane Katrina?

☐ Yes ☐ No

If "yes," date of claim: _____

Reason for claim: _____

I. Were you ever rejected or discharged from military service for any reason relating to your health or physical condition?

☐ Yes ☐ No

If "yes," then state the reason for the health-related rejection or discharge and when this happened.

_____

_____

Do you, or have you ever received military disability benefits?

☐ Yes ☐ No

If "yes," then state the reason for the benefit.

_____

_____

section continues on next page

J. Have you ever filed a lawsuit, participated in a class action lawsuit or settlement, or otherwise made a legal claim or settled any claim relating to any bodily injury, illness, or physical harm?

☐ Yes ☐ No

If "yes," please provide the following for each lawsuit or claim:

Name and address of lawyer who represented you in your claim or lawsuit: _____

_____

Court in which the lawsuit was brought or claim was made: _____

The civil action or docket number assigned to the lawsuit or claim: _____

File date: _____

Claimed disease or condition: _____

Claimed cause of disease or condition: _____

Result of lawsuit or claim (verdict, dismissal, settlement): _____

IV. Medical Background

A. Smoking History

1. Have you ever smoked cigarettes, cigars, a pipe, or other substances?

☐ Yes ☐ No

If "yes," please describe the substances smoked, amount:

a. Substances smoked: _____

b. Dates smoked: _____

c. Amount smoked (*e.g.*, pack per day of cigarettes): _____

_____

2. Have you ever used any other form of tobacco (*e.g.*, snuff, dipping)?

☐ Yes ☐ No

If "yes," please identify:

a. What form: _____

b. Dates of use: _____

c. Amount of use: _____

section continues on next page

3. Has anyone living with you ever smoked cigarettes, cigars, a pipe, or other substances?

☐ Yes ☐ No

If "yes," please identify:

a. Person/Relationship: _____

b. Year started while living with you: _____

c. Year stopped while living with you: _____

d. Substances and amount smoked (*e.g.*, Number of packs per day of cigarettes): _____

_____

B. Alcohol Consumption

Please describe your history of alcohol use (include how many drinks you have in a typical week, what type of drinks, how many years you have been drinking, amounts of alcohol used over those years, any medical conditions that might be related to your alcohol use, and any treatment programs you participated in related to alcohol use).

_____

_____

_____

_____

C. Drug Consumption

Please identify any prescription medications, over-the-counter medications, dietary supplements, or other substances you have taken in the previous 10 years. For each one taken, please describe the dates of use and frequency of use.

_____

_____

_____

_____

D. Hospitalizations

Please provide the following information for each hospitalization that you have had. If you cannot remember all of the details, please list as much information as you can. If necessary, please provide the requested information on additional pages.

Name of hospital: _____

section continues on next page

Address: _____

Phone: _____

Reason(s) for hospitalization(s): _____

_____

E. Health Care Providers

Please provide on a separate sheet, the following information for each doctor, clinic or healthcare provider that you have seen or who has treated you during the last twenty years, including any hospitalizations or surgeries for any physical condition. If you cannot recall all of the details regarding the healthcare providers that you have seen, please provide as much information as you can.

Name: _____

Specialty, if any: _____

Address: _____

Phone: _____

Reason for visit or hospitalization: _____

Date of visit or hospitalization: _____

F. Past Medical Conditions and Treatment

Have you been ever diagnosed or consulted a doctor, clinic, or other healthcare provider concerning any of the following conditions (check all that apply):

- ☐ Frequent or severe headaches
- ☐ Dizziness or fainting
- ☐ Hearing loss
- ☐ Chronic or frequent colds
- ☐ Sinusitis
- ☐ Hay fever
- ☐ Skin disease
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ Scarred lung
- ☐ HIV / AIDS
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Paralysis
- ☐ Epilepsy
- ☐ Sleeping disorder/sleep apnea
- ☐ Eating disorder
- ☐ Extreme fatigue
- ☐ Memory problems
- ☐ Cancer (non-skin; including leukemia or lymphoma):
  Insert type(s)_____
- ☐ Skin cancer:
  Insert type(s)_____
- ☐ Attention deficit disorder
- ☐ Allergic rhinitis
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Epistaxis (nose bleeding)
- ☐ Conjunctivitis
- ☐ Dry eye syndrome
- ☐ Anemia:
  Insert type_____
- ☐ Asthma
- ☐ Bronchitis
- ☐ Corneal ulcer
- ☐ Seizure
- ☐ Diabetes
- ☐ Hypertension
- ☐ Ulcerative colitis

Section continues on next page

☐	Chest pains	☐	Heart attack	☐	Crohn's disease
☐	Chronic cough	☐	Heart failure	☐	Osteomyelitis
☐	Heart conditions	☐	Sarcoidosis	☐	Epstein Barr virus
☐	High blood pressure	☐	Lupus	☐	Gastric/stomach ulcer
☐	Liver conditions	☐	Organic brain syndrome	☐	Allergies:
☐	Sugar or albumin in urine				Insert type(s)_____

For each of the conditions you have identified above, please provide the following information. If you cannot remember all of the details, please list as much information as you can. Attach additional pages if necessary.

Condition: _____

Name of doctor or facility: _____

Address: _____

Date: _____

Diagnosis: _____

Treatment: _____

Medications: _____

Did the condition resolve? _____

Current status of the condition: _____

V. Family History

To the best of your knowledge, have any of your parents, grandparents, siblings, or children had any of the conditions listed above in section IV.F?

Family member	Cancer (including leukemias or lymphomas)? If "yes," provide the type and date of diagnosis	Disorders/conditions/diseases? If "yes," provide the type and date of diagnosis	Date of birth	Date of death
Mother				
Father				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				
Siblings				
Aunts/Uncles/Cousins				

VI. Physical Injuries, Illness and Damages

A. Please describe the LATER-MANIFESTED PHYSICAL CONDITION you claim.

1. Nature of physical injuries or illness: _____

   _____

2. The date that you first developed symptoms of the physical injuries or illness: _____

3. How you first became aware of the symptoms of the physical injuries or illness: _____

   _____

4. Whether those injuries or illnesses are continuing: _____

5. Please complete the following for the doctor or other healthcare provider who first diagnosed the physical injury or illness above.

   a. Name: _____

   b. Address: _____

   c. Date of first consultation with that healthcare provider: _____

   d. Date of last consultation: _____

   e. Do you plan to continue to consult with that healthcare provider?

   ☐ Yes ☐ No

6. Did you see any other doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

   ☐ Yes ☐ No

   If "yes," please complete the following for each healthcare provider:

   a. Name: _____

   b. Address: _____

   c. Date of first consultation with that healthcare provider: _____

   d. Date of last consultation: _____

   e. Do you plan to continue to consult with that healthcare provider?

   ☐ Yes ☐ No

section continues on next page

B. Have you had any discussions with any doctor or other healthcare provider about whether oil, other hydrocarbons, or other substances released from the MC252 WELL and/or the *Deepwater Horizon* and its appurtenances, and/or dispersants or decontaminants used in connection with the RESPONSE ACTIVITIES contributed to your physical injuries or illness?

☐ Yes ☐ No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion.

_____

_____

_____

VII. Extent And Duration of Exposure to Oil, Other Hydrocarbons, Or Other Substances Released From The MC252 WELL And/Or The *Deepwater Horizon* And Its Appurtenances, And/Or Dispersants Or Decontaminants Used In Connection With The RESPONSE ACTIVITIES

A. Please specifically describe the circumstances and duration of your exposure to oil, other hydrocarbons, or other substances released from the MC252 WELL and/or the *Deepwater Horizon* and its appurtenances, and/or dispersants and/or decontaminants used in connection with the RESPONSE ACTIVITIES (use specific dates, locations, and activities):

_____

_____

_____

B. For claims related to your role as a CLEAN-UP WORKER, include your role in the clean-up activities, the name of your employer, and where you were working:

_____

_____

_____

VIII. Documents

Please provide a copy of all of your documents and things which fall into the categories listed below.

1. Signed HIPAA authorizations for the release of your medical records (Appendix B).
2. Signed authorizations for the release of your employment records (Appendix C).
3. A copy of any medical records in your possession that you wish to be considered from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions.
4. If you have been the claimant or subject of any worker's compensation, Social Security, or other disability proceeding, all documents relating to such proceeding.
5. Decedent's death certificate (if applicable) and the results of any post-mortem examination (if applicable).

IX. Declaration

This form is an official court document sanctioned by the COURT that presides over the class actions arising from the *DEEPWATER HORIZON* INCIDENT. Submitting this document to the CLAIMS ADMINISTRATOR is equivalent to filing it with the COURT, and I declare under penalty of perjury that the information provided in this form is true and correct to the best of my knowledge, information, and belief.

_____ Date: ____ / ____ / ____

Signature of MEDICAL BENEFITS SETTLEMENT CLASS MEMBER

Or

_____

Signature of AUTHORIZED REPRESENTATIVE

You may complete this form online via the Medical Benefits Settlement Web Portal at www.deepwaterhorizonmedicalsettlement.com, but you must print it out in its entirety and return the signed form, the information of the AUTHORIZED REPRESENTATIVE, if any, and the employment records authorizations at Appendix B, and any records or other materials in support of your claim to:

DEEPWATER HORIZON MEDICAL BENEFITS
CLAIMS ADMINISTRATOR
P.O. Box 3420
Portland, OR 97208-3420

MEDIATION INFORMATION FORM - Appendix A
AUTHORIZED REPRESENTATIVES

Complete this Appendix only if you are an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, and the information has changed since you submitted your NOTICE OF INTENT TO SUE.

A. Check all that apply for the MEDICAL BENEFITS SETTLEMENT CLASS MEMBER for whom you are an AUTHORIZED REPRESENTATIVE.

☐ Minor ☐ Person Lacking Capacity or Incompetent Person ☐ Deceased Person

If the person for whom you are an AUTHORIZED REPRESENTATIVE is a deceased person, please state the date of the death: ____ / ____ / ____

B. Provide the following information about yourself (the AUTHORIZED REPRESENTATIVE filling out this form):

First Name M.I. Last Name

Any other names used in the last 10 years

Street Address

City State Zip Code

Telephone Number Fax Number

___ - ___ - ____ ___ - ___ - ____

E-mail Address

C. Identify the authority giving you, the AUTHORIZED REPRESENTATIVE, the right to act on behalf of the person identified in Section I above. You must also provide copies of documentation verifying your authority to act, such as a power of attorney or a court order stating your authority to act, or, if no such documents are available, documents establishing your legal relationship to the person identified in Section I of the MEDIATION INFORMATION FORM. AUTHORIZED REPRESENTATIVES of a deceased person must also provide a copy of the death certificate.

MEDIATION INFORMATION FORM - Appendix B

HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508

When submitting a MEDIATION INFORMATION FORM, you must also complete and submit this authorization. Submitting this form authorizes BP, subject to the terms of the MEDICAL SETTLEMENT AGREEMENT, to collect medical records from a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER'S healthcare providers. The information obtained from your healthcare providers pursuant to this authorization will be used by BP and a mediator in evaluating and mediating your claim for a LATER-MANIFESTED PHYSICAL CONDITION and in a BACK-END LITIGATION OPTION LAWSUIT. BP will promptly provide you a copy of the records it obtains pursuant to this authorization without cost to you.

Please fill out the fields and sign the document below. If you are an AUTHORIZED REPRESENTATIVE of a minor, incapacitated or incompetent person, or deceased person, please provide information for that person and sign below.

The capitalized terms in this form are defined in the MEDICAL BENEFITS CLASS CLASS SETTLEMENT AGREEMENT, which is available at www.deepwaterhorizonmedicalsettlement.com or by calling toll free 1-877-545-5111.

You should keep a copy of anything submitted to the CLAIMS ADMINISTRATOR.

HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508

NAME OF MEDICAL BENEFITS SETTLEMENT CLASS MEMBER

First Name M.I. Last Name

Date of Birth (mm/dd/yyyy) Social Security Number

__ __ / __ __ / __ __ __ __ __ __ __ - __ __ - __ __ __ __

I, the **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** named above, hereby authorize my health care provider(s), health plan(s), and health insurer(s) to disclose my health records to BP through its counsel, the law firm of Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA 70139-5099 (hereafter referred to as "**Recipient**"), for the purpose of the evaluation and mediation of my claim for a LATER-MANIFESTED PHYSICAL CONDITION, including the submission of my health records to a mediator.

I hereby grant any reimbursement claim, lien holder or state or federal agency, and the contract representatives of either, permission to share with the **Recipient** all reimbursement claim and lien information and confirming **health records** regarding any conditional payments made, or medical care performed, by the claim / lien holder relating to LATER-MANIFESTED PHYSICAL CONDITIONS within the meaning of the MEDICAL BENEFITS CLASS ACTION SETTLEMENT (collectively referred to as "**lien information**").

As referred to above, my **health records** include any and all of the following:

Records of my medical condition(s), diagnoses, and treatment, including, but not limited to, physician's records; surgeons' records; discharge summaries; progress notes; consultations; pharmaceutical records; medication sheets; patient information sheets; consents for treatment; medical reports; x-rays and x-ray reports; CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films; interpretations of diagnostic tests; pathology materials, slides, tissues, and laboratory results and/or reports; consultations; physical therapy records; drug and/or alcohol abuse records; HIV/AIDS diagnosis and/or treatment; physicals and histories; correspondence; psychiatric records; psychological records; psychometric test results; social worker's records; other

information pertaining to the physical and mental condition; all hospital summaries and hospital records including, but not limited to, admitting records; admitting histories and physicals; case records, discharge summaries; physician's orders, progress notes, and nurses' notes; medical record summaries; emergency room records; all other hospital documents and memoranda pertaining to any and all hospitalizations and/or out-patient visits; and

Any and all insurance records; statements of account, bills or billing records, or invoices; any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, or diagnosis pertaining to my health.

I understand that the information in my **health records** may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I wish to revoke the authorization, I must do so in writing and must provide my written revocation to any and all of my health care providers, health plans, or health insurers, state or federal agencies and all other third party lien holders to which the revocation will apply. I understand that the revocation will not apply to any disclosures that have already been made in reliance on this authorization prior to the date upon which the disclosing health care provider, health plan, health insurer, or such other third party receives my written revocation.

I understand that my authorization of the disclosure of my **health records** and **lien information** is voluntary and that I therefore can refuse to sign this authorization. I also understand that I do not need to sign this authorization in order to obtain health treatment or to receive or be eligible to receive benefits for coverage of health treatment.

I understand that, once disclosed to the **Recipient**, my **health records** and **lien information** may not be protected by federal privacy law and could be further disclosed to others without my authorization.

This authorization expires upon final resolution of my claim for a LATER-MANIFESTED PHYSICAL CONDITION in the Medical Benefits Class Action Settlement in MDL 2179.

I have a right to receive and retain a copy of this authorization when signed below.

Name of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** (print)	Signature	Date
OR		
Name and title of AUTHORIZED REPRESENTATIVE authorized to act on behalf of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** as:	Signature	Date
Relationship to **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER**		

MEDIATION INFORMATION FORM - Appendix C
Authorization And Direction For Disclosure And Release Of Employee/Personnel Records

When submitting a MEDIATION INFORMATION FORM, you must also complete and submit this authorization. Submitting this form authorizes BP, subject to the terms of the MEDICAL SETTLEMENT AGREEMENT, to collect employment and personnel records from your past and present employers. The information obtained pursuant to this authorization will be used by BP and a mediator in evaluating and mediating your claim for a LATER-MANIFESTED PHYSICAL CONDITION and in a BACK-END LITIGATION OPTION LAWSUIT.

Please fill out the fields and sign the document below. If you are an AUTHORIZED REPRESENTATIVE of a minor, incapacitated or incompetent person, or deceased person, please provide information for that person and sign below.

The capitalized terms in this form are defined in the MEDICAL SETTLEMENT AGREEMENT, which is available at www.deepwaterhorizonmedicalsettlement.com or by calling toll free 1-877-545-5111.

You should retain a copy of anything submitted to the CLAIMS ADMINISTRATOR.

Authorization And Direction For Disclosure And Release Of Employee/Personnel Records

EMPLOYER:

Name: _____

Address: _____

_____

EMPLOYEE:

Name: _____

Date of Birth: _____

Social Security No: _____

Address: _____

_____

I, the **EMPLOYEE** named above, do hereby **AUTHORIZE** AND **DIRECT** my past or current **EMPLOYER** identified above to disclose and release to BP through its counsel, the law firm of Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA 70139-5099, and/or its duly authorized representative any and all records, files, documents and other information concerning my employment with the above-named **EMPLOYER**.

This authorization expires upon a final resolution of my claim for a LATER-MANIFESTED PHYSICAL CONDITION in the MEDICAL BENEFITS CLASS ACTION SETTLEMENT in MDL 2179.

Dated this _____ day of _____ 20___.

_____

Printed **Employee** Name

_____

Employee Signature

To be filled out by an Authorized Representative for an **Employee** who is a minor, incapacitated or incompetent person, or deceased person:

_____

Name of AUTHORIZED REPRESENTATIVE authorized to act on **Employee's** behalf

_____

Signature of AUTHORIZED REPRESENTATIVE authorized to act on **Employee's** behalf

_____

Relationship to **Employee**