MEDICAL BENEFITS CLASS ACTION SETTLEMENT
CLASS MEMBERSHIP CHALLENGE FORM

Complete this form and submit it to the CLAIMS ADMINISTRATOR (at the address at the end of the form) if you think the CLAIMS ADMINISTRATOR erred in its determination that you are not a member of the Medical Benefits Settlement Class.

NOTE THAT IN ORDER TO CHALLENGE THE CLAIMS ADMINISTRATOR'S DETERMINATION, YOU MUST SUBMIT THIS FORM WITHIN 60 DAYS OF RECEIPT OF THE CLAIMS ADMINISTRATOR'S DETERMINATION.

After you submit your completed CLASS MEMBERSHIP CHALLENGE FORM to the Claims Administrator, the Court will review your challenge and the documentation you previously submitted in support of your claim.

This form must be signed personally by the person challenging the Claims Administrator's determination, or in the case of a person who is (1) a minor, (2) lacks capacity or is incompetent, or (3) deceased, by his or her AUTHORIZED REPRESENTATIVE. If you are an AUTHORIZED REPRESENTATIVE, please provide the information in this form for the person you represent (unless otherwise directed).

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.

I. Contact Information (of the person who filed the claim).

Claimant ID Number

First Name | M.I. | Last Name

Any other names used in the last 10 years

Current or Last Known Street Address

City | State | Zip Code

Section continues on next page

Telephone Number (Daytime)

Telephone Number (Evening)

Cellular Number

E-mail address

Date of Birth (MM/DD/YYYY)

Gender

☐ Male ☐ Female

II. Representation by Legal Counsel

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

☐ Yes ☐ No

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

Lawyer's First Name Middle Initial Lawyer's Last Name

Law Firm's Name

Law Firm's Street Address

City State Zip Code

Telephone Number

Fax Number

III. Persons Who are Minors, Lack Capacity or are Incompetent, or are Deceased

Complete this section only if you are an AUTHORIZED REPRESENTATIVE completing this form on behalf of a person who is (1) a minor, (2) lacks capacity or is incompetent, or (3) is deceased.

A. Check all that apply for the person 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

Firm Name

Street Address

City State Zip Code

Telephone Number (Daytime)

– –

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 above. AUTHORIZED REPRESENTATIVES of a deceased person must also provide a copy of the death certificate.

IV. Reason for Challenge

State the reason that you believe the CLAIMS ADMINISTRATOR erred in determining that you are not a member of the Medical Benefits Settlement Class. Please do not submit any documents with this CLASS MEMBERSHIP CHALLENGE FORM (other than the AUTHORIZED REPRESENTATIVE documents required to be submitted under Section III above, if applicable). You may, however, direct the CLAIMS ADMINISTRATOR to records you have previously provided.

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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

_____ Date: ____ / ____ / ____
Signature of AUTHORIZED REPRESENTATIVE, if any

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 submit the signed form to:

DEEPWATER HORIZON MEDICAL BENEFITS
CLAIMS ADMINISTRATOR
935 Gravier Street, Suite 1400
New Orleans, LA 70112