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.		Co	nta	ct In	fori	mati	ion (of t	he p	ers	on v	who	file	d tl	he c	lain	n).										
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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):
communications about your challenge will be made to your lawyer): Lawyer's First Name Middle Initial Lawyer's Last Name
Lawyer's First Name Middle Initial Lawyer's Last Name
Lawyer's First Name Middle Initial Lawyer's Last Name Law Firm's Name
Lawyer's First Name Middle Initial Lawyer's Last Name
Lawyer's First Name Middle Initial Lawyer's Last Name Law Firm's Name Law Firm's Street Address
Lawyer's First Name Middle Initial Lawyer's Last Name Law Firm's Name

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. Check all that apply for the person for whom you are an AUTHORIZED REPRESENTATIVE. A. 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 Zip Code State 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.

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

III.

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 <u>not</u> 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.
the filin	form is an official court document sanctioned by the COURT that presides over the class actions arising from <i>DEEPWATER HORIZON</i> INCIDENT. Submitting this document to the CLAIMS ADMINISTRATOR is equivalent to g it with the COURT, and I declare under penalty of perjury that the information provided in this form is true correct to the best of my knowledge, information, and belief.
 Sign	Date:/ Date:/
or	
	Date:/

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

Signature of AUTHORIZED REPRESENTATIVE, if any