

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
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Firm Name

Street Address

City	State	Zip Code
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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.

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.

Signature of MEDICAL BENEFITS SETTLEMENT CLASS MEMBER Date: ____ / ____ / ____

or

Signature of AUTHORIZED REPRESENTATIVE, if any 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**