MEDICAL BENEFITS CLASS ACTION SETTLEMENT DATA DISCLOSURE FORM

Complete this form and submit it to the CLAIMS ADMINISTRATOR (at the address at the end of this form) if you think you may be a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER and want to request information that may be related to you from within the databases and documentation that BP provided to the CLAIMS ADMINISTRATOR, as described in the MEDICAL SETTLEMENT AGREEMENT. Such information may include, among other things, information and/or records concerning the identification of persons who were CLEAN-UP WORKERS and/or who visited medic stations funded by BP for CLEAN-UP WORKERS.

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 submitting this form (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.

Attorneys may not sign this form on behalf of a client.

The information sought below will assist the CLAIMS ADMINISTRATOR in conducting searches for information related to you in the databases and documentation provided to it by BP. The more information you provide, the more likely it is that the CLAIMS ADMINISTRATOR will be able to locate information related to you in those databases and documentation. If, however, you do not have or choose not to provide all or certain of the information requested, the CLAIMS ADMINISTRATOR will use the information that you do provide to conduct its searches of the databases and documentation provided to it by BP.

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

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Cellular Number
Date of Birth (MM/DD/YYYY) Gender Male Female
Last Four Digits of Social Security Number
Badge ID Number (5 or 6 numbers, sometimes followed by 2 or 3 letters) 2 2 7 -
Training ID Number P E C
Name of Employer(s) when performing Response Activities
1

Address at which Claimant resided when performing Response Activities (if different than the address above)
City State Zip Code
City State Zip Code Phone Number(s) Claimant used when performing Response Activities (if different than the number(s) above)
Phone Number(s) Claimant used <u>when performing Response Activities</u> (if different than the number(s) above)

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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 and a copy of your driver's license or other government-issued identification to:

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