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.

I. Contact Information (of the person whose information is being requested).

Claimant ID Number (if one has been assigned)

First Name | Middle Name

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

			–				–				

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. _____
2. _____
3. _____

Address at which Claimant resided *when performing Response Activities* (if different than the address above)

City

State

Zip Code

Phone Number(s) Claimant used *when performing Response Activities* (if different than the number(s) above)

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Any other information you think may help us determine whether there is any information relating to you in the databases and documentation provided to the CLAIMS ADMINISTRATOR by BP (for example, name and telephone number of Emergency Contact, name of boat or vessel on which Response Activities were performed, nickname you might have used).

_____

_____

_____

_____

II. Representation by Legal Counsel (All fields *required* if represented by counsel)

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

☐ Yes ☐ No

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

Lawyer's First Name | Lawyer's Last Name

Law Firm's Name

Lawyer's Street Address

City | State | Zip Code

Telephone Number – – | Fax Number – –

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

Complete this section only if you are an AUTHORIZED REPRESENTATIVE of a person who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, and are seeking information on behalf of the such person. (All fields *required* if represented by AUTHORIZED REPRESENTATIVE)

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

Any Other Names Used in the Last 10 Years

Section Continues on Next Page

Street Address

City | State | Zip Code

Telephone Number

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. CERTIFICATION: I certify that I am the person identified above in Section I, or the AUTHORIZED REPRESENTATIVE for such person identified above in Section III. I hereby request and authorize the CLAIMS ADMINISTRATOR to provide me, or if represented, my counsel, with a copy of all information pertaining to me that was provided by BP to the CLAIMS ADMINISTRATOR pursuant to the MEDICAL SETTLEMENT AGREEMENT.

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.

YOU MUST ATTACH A COPY OF YOUR DRIVER'S LICENSE OR OTHER GOVERNMENT-ISSUED IDENTIFICATION WHEN YOU SUBMIT THIS FORM TO THE CLAIMS ADMINISTRATOR.

_____ Date: ____ / ____ / ____
Signature of person requesting information

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 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