

**MEDICAL BENEFITS CLASS ACTION SETTLEMENT**  
**MEDIATION INFORMATION FORM**

All information relating to you that is disclosed to or obtained by the CLAIMS ADMINISTRATOR, BP, healthcare providers, or any other authorized entity in connection with exercise of a BACK-END LITIGATION OPTION may be used only by: (i) you, upon request; (ii) BP defendants in a BACK-END LITIGATION OPTION mediation or a BACK-END LITIGATION OPTION LAWSUIT; (iii) the mediator of your BACK-END LITIGATION OPTION MEDIATION; or (iv) the CLAIMS ADMINISTRATOR, healthcare providers, or any other authorized entity to the extent necessary for the administration of this MEDICAL SETTLEMENT AGREEMENT according to its terms, including your exercise of the BACK-END LITIGATION OPTION.

You are receiving this form because you submitted a NOTICE OF INTENT TO SUE and a BP defendant has elected to mediate your claim. You must submit this completed form to the CLAIMS ADMINISTRATOR within 60 days of the CLAIMS ADMINISTRATOR sending you the NOTICE OF MEDIATION.

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 asserting a claim, and also submit Appendix A.

Print or type all responses. Attach additional sheets if needed. In completing this form, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you are represented by counsel, you may and should consult with your attorney if you have any questions regarding the completion of this form. Your lawyer may submit this form for you, but may not sign it for you.

The capitalized terms in this form are defined in the MEDICAL SETTLEMENT AGREEMENT, which is available at [www.deepwaterhorizonmedicalsettlement.com](http://www.deepwaterhorizonmedicalsettlement.com) or by calling toll free 1-877-545-5111.

**You should submit all your materials together. You should retain a copy of anything submitted to the CLAIMS ADMINISTRATOR.**

I. Personal & Background Information (update information if it has changed since you submitted your NOTICE OF INTENT TO SUE)

Claimant ID Number

[Grid for Claimant ID Number]

First Name

M.I. Last Name

[Grid for Name Fields]

Complete the remaining items only if your information has changed since you submitted your NOTICE OF INTENT TO SUE.

Any Other Names Used in the Last 10 Years

[Grid for Any Other Names]

Current or Last Known Street Address

[Grid for Street Address]

City

State

Zip Code

[Grid for City, State, Zip Code]

Telephone Number (Daytime)

Telephone Number (Evening)

[Grid for Daytime Telephone Number]

Cellular Number

Fax Number

[Grid for Cellular and Fax Numbers]

E-mail Address (if any)

[Grid for E-mail Address]

Date of Birth (mm/dd/yyyy)

Social Security Number

[Grid for Date of Birth and Social Security Number]

Driver's License Number / Other State ID

State

Gender

[Grid for License Number, State, and Gender]

Male

Female

II. Representation by Legal Counsel

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

Yes

No

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

Lawyer's First Name

M.I.

Lawyer's Last Name

[Grid for Lawyer's Name Fields]

Law Firm's Name

[Grid for Law Firm's Name]

Section continues on next page

Law Firm's Street Address

\_\_\_\_\_

City

\_\_\_\_\_

State

Zip Code

Telephone Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Fax Number

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Lawyer's E-mail Address

\_\_\_\_\_

### III. Background Information

#### A. Marital Status

Single

Married

Separated

Divorced

Widowed

If married, name of spouse: \_\_\_\_\_ Date of marriage: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### B. Do you have children?

Yes

No

If "yes," please provide name(s) and date(s) of birth:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### C. Residence History: Please complete the following information regarding your residences for the past 20 years.

Street address	City	State	Zip code	Date moved in	Date moved out

*Section continues on next page*

1. To the best of your knowledge, did you ever reside within 1 mile of any of the following?

Factory/plant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	What kind: _____
Refinery	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Superfund site	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	

2. Did you live in a mobile home provided as a result of Hurricane Katrina?

Yes     No

If "yes," how long did you live in the mobile home? \_\_\_\_\_

3. Have you lived in a residence with any mold problems?

Yes     No

If "yes," how long did you live in the residence? \_\_\_\_\_

4. Have you filed any claim for mold-related problems?

Yes     No

5. Have you lived in a residence with any Chinese drywall?

Yes     No

If "yes," how long did you live in the residence? \_\_\_\_\_

Have you filed a claim for Chinese drywall?

Yes     No

6. Have you lived in a residence with asbestos insulation, pipe covering, or decorative ceiling?

Yes     No

If "yes," how long did you live in the residence? \_\_\_\_\_

7. How many hours a day do you estimate that you spend in an automobile? \_\_\_\_\_

**D.1. Employment History:** Please complete the following information regarding all employers that you have had in the last 20 years. If necessary, please provide the information for additional employers on additional pages.

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

*section continues on next page*

Job Duties: \_\_\_\_\_

Date(s) of Employment: \_\_\_\_\_

2. Have you ever worked in one of the following occupations, and if so, for how many years?

<u>Occupation</u>	<u>Length of Employment</u>	<u>Occupation</u>	<u>Length of Employment</u>
<input type="checkbox"/> Auto repair	_____	<input type="checkbox"/> Dry cleaning	_____
<input type="checkbox"/> Garage worker	_____	<input type="checkbox"/> Electronics	_____
<input type="checkbox"/> Brake lining	_____	<input type="checkbox"/> Firefighter	_____
<input type="checkbox"/> Assembly/machine operator	_____	<input type="checkbox"/> Hairdressing/cosmetology	_____
<input type="checkbox"/> Coal miner	_____	<input type="checkbox"/> Farming	_____
<input type="checkbox"/> Carpentry	_____	<input type="checkbox"/> Textile worker	_____
<input type="checkbox"/> Chemist	_____	<input type="checkbox"/> Arborist	_____
<input type="checkbox"/> Cook/chef	_____	<input type="checkbox"/> Fishing	_____
<input type="checkbox"/> Janitor	_____	<input type="checkbox"/> Mining	_____
<input type="checkbox"/> Chemical industry	_____	<input type="checkbox"/> Highway repair	_____
<input type="checkbox"/> Construction	_____	<input type="checkbox"/> Pipefitter	_____
<input type="checkbox"/> Painter	_____	<input type="checkbox"/> Sandblaster	_____
<input type="checkbox"/> Lumber/sawmill	_____	<input type="checkbox"/> Gasoline station	_____
<input type="checkbox"/> Welder	_____	<input type="checkbox"/> Railroad/train yard	_____
<input type="checkbox"/> Trucking	_____	<input type="checkbox"/> Rubber industry	_____
<input type="checkbox"/> Metal Refining	_____	<input type="checkbox"/> Boating industry	_____
<input type="checkbox"/> Petroleum industry	_____	<input type="checkbox"/> Utility worker	_____
<input type="checkbox"/> Pulp/paper production	_____	<input type="checkbox"/> Photography/photo developer	_____
<input type="checkbox"/> Plumbing	_____	<input type="checkbox"/> Power lineman	_____
<input type="checkbox"/> Teaching	_____	<input type="checkbox"/> Commercial fishing	_____
<input type="checkbox"/> Vapor degreasing	_____	<input type="checkbox"/> Foundry	_____
<input type="checkbox"/> Laboratory work	_____	<input type="checkbox"/> Shipyard	_____
<input type="checkbox"/> Funeral director/embalmer	_____	<input type="checkbox"/> Pest control/exterminating	_____
<input type="checkbox"/> Nursing	_____	<input type="checkbox"/> Airplane pilot	_____
<input type="checkbox"/> Tankers/seaman	_____	<input type="checkbox"/> Flight attendant	_____
<input type="checkbox"/> Woodworking	_____	<input type="checkbox"/> Butcher	_____
<input type="checkbox"/> Slaughterhouse or abattoir	_____	<input type="checkbox"/> Clinical/science laboratory	_____
<input type="checkbox"/> Nuclear power plant	_____	<input type="checkbox"/> Veterinary practitioner	_____

3. Have you ever been in contact with or worked at a job handling any of the following materials?

Aerosols	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Acid mists	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Acrylamide	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Agent Orange	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Aldrin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Anesthetic gases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Arsenic	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Asbestos	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Asphalt and tar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Benzene	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Beryllium	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Cadmium	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Carbon black	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Chlordane	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Chromium	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Coal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Coal tar	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Crude oil	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Cotton	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Creosote	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Crop dust and sprays	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
DDT	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Degreasing agents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Dieldrin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Diesel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Engine exhaust	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Dioxin (TCDD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Dyes or stains	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Formaldehyde	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Fiberglass	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Gasoline	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Insulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure
Lead	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not sure

*section continues on next page*

Mercury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Nickel	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Paints	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Pentachlorophenol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
PCBs	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Pesticides or fungicides	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Phenol	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Plastics	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Silica	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Solvents	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Soots or tars	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Mineral oils	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
TCE	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Toluene diisocyanate	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Vinyl chloride	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Welding fumes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Wood dust/sawdust	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
X-rays	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure
Radioactive materials	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not sure

**E. Education History:** Please provide the following information about your education.  
 If you attended school beyond high school, please complete the following for each school that you attended after high school. If necessary, please provide the requested information for additional schools on additional pages.

Name of School	City, State	Dates of Attendance

**F.** Have you had any health insurance provided either through company employment (self, spouse, or parent), self-purchase of insurance or through governmental health agency (Medicare, state plan) to you and/or paid medical bills on your behalf from January 1, 2000 through the present?

Yes     No

If "yes," please complete the following:

Name of insurance provider	Address

*section continues on next page*

G. Have you applied for worker's compensation, social security, or state or federal disability benefits in the past?

Yes  No

If "yes," please complete the following for each application. If you cannot recall all of the details regarding such application(s), please provide as much information as you can. If necessary, please provide the requested information for additional claims on additional pages.

1. Date (or year) of application: \_\_\_\_\_
2. Type of benefits: \_\_\_\_\_
3. Amount awarded: \_\_\_\_\_
4. Basis of your claim: \_\_\_\_\_
5. If denied, reason for denial: \_\_\_\_\_
6. Location claim was filed: \_\_\_\_\_
7. To what agency or company you submitted your application: \_\_\_\_\_

H. Have you made any claim related to Hurricane Katrina?

Yes  No

If "yes," date of claim: \_\_\_\_\_

Reason for claim: \_\_\_\_\_

I. Were you ever rejected or discharged from military service for any reason relating to your health or physical condition?

Yes  No

If "yes," then state the reason for the health-related rejection or discharge and when this happened.

\_\_\_\_\_  
\_\_\_\_\_

Do you, or have you ever received military disability benefits?

Yes  No

If "yes," then state the reason for the benefit.

\_\_\_\_\_  
\_\_\_\_\_

*section continues on next page*



J. Have you ever filed a lawsuit, participated in a class action lawsuit or settlement, or otherwise made a legal claim or settled any claim relating to any bodily injury, illness, or physical harm?

Yes     No

If "yes," please provide the following for each lawsuit or claim:

Name and address of lawyer who represented you in your claim or lawsuit: \_\_\_\_\_

\_\_\_\_\_

Court in which the lawsuit was brought or claim was made: \_\_\_\_\_

The civil action or docket number assigned to the lawsuit or claim: \_\_\_\_\_

File date: \_\_\_\_\_

Claimed disease or condition: \_\_\_\_\_

Claimed cause of disease or condition: \_\_\_\_\_

Result of lawsuit or claim (verdict, dismissal, settlement): \_\_\_\_\_

#### IV. Medical Background

##### A. Smoking History

1. Have you ever smoked cigarettes, cigars, a pipe, or other substances?

Yes     No

If "yes," please describe the substances smoked, amount:

a. Substances smoked: \_\_\_\_\_

b. Dates smoked: \_\_\_\_\_

c. Amount smoked (e.g., pack per day of cigarettes): \_\_\_\_\_

\_\_\_\_\_

2. Have you ever used any other form of tobacco (e.g., snuff, dipping)?

Yes     No

If "yes," please identify:

a. What form: \_\_\_\_\_

b. Dates of use: \_\_\_\_\_

c. Amount of use: \_\_\_\_\_

*section continues on next page*

3. Has anyone living with you ever smoked cigarettes, cigars, a pipe, or other substances?

Yes       No

If "yes," please identify:

a. Person/Relationship: \_\_\_\_\_

b. Year started while living with you: \_\_\_\_\_

c. Year stopped while living with you: \_\_\_\_\_

d. Substances and amount smoked (e.g., Number of packs per day of cigarettes): \_\_\_\_\_

\_\_\_\_\_

**B. Alcohol Consumption**

Please describe your history of alcohol use (include how many drinks you have in a typical week, what type of drinks, how many years you have been drinking, amounts of alcohol used over those years, any medical conditions that might be related to your alcohol use, and any treatment programs you participated in related to alcohol use).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**C. Drug Consumption**

Please identify any prescription medications, over-the-counter medications, dietary supplements, or other substances you have taken in the previous 10 years. For each one taken, please describe the dates of use and frequency of use.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Hospitalizations**

Please provide the following information for each hospitalization that you have had. If you cannot remember all of the details, please list as much information as you can. If necessary, please provide the requested information on additional pages.

Name of hospital: \_\_\_\_\_

*section continues on next page*

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason(s) for hospitalization(s): \_\_\_\_\_

\_\_\_\_\_

**E. Health Care Providers**

Please provide on a separate sheet, the following information for each doctor, clinic or healthcare provider that you have seen or who has treated you during the last twenty years, including any hospitalizations or surgeries for any physical condition. If you cannot recall all of the details regarding the healthcare providers that you have seen, please provide as much information as you can.

Name: \_\_\_\_\_

Specialty, if any: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Reason for visit or hospitalization: \_\_\_\_\_

Date of visit or hospitalization: \_\_\_\_\_

**F. Past Medical Conditions and Treatment**

Have you been ever diagnosed or consulted a doctor, clinic, or other healthcare provider concerning any of the following conditions (check all that apply):

<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Dizziness or fainting	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Epistaxis (nose bleeding)
<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	Sleeping disorder/sleep apnea	<input type="checkbox"/>	Conjunctivitis
<input type="checkbox"/>	Chronic or frequent colds	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Dry eye syndrome
<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	Extreme fatigue	<input type="checkbox"/>	Anemia:
<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	Memory problems		Insert type _____
<input type="checkbox"/>	Skin disease	<input type="checkbox"/>	Cancer (non-skin; including leukemia or lymphoma):	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Thyroid		Insert type(s) _____	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Skin cancer:	<input type="checkbox"/>	Corneal ulcer
<input type="checkbox"/>	Scarred lung		Insert type(s) _____	<input type="checkbox"/>	Seizure
<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Attention deficit disorder	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Allergic rhinitis	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Ulcerative colitis

*Section continues on next page*

<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Crohn's disease
<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	Osteomyelitis
<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	Epstein Barr virus
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Gastric/stomach ulcer
<input type="checkbox"/>	Liver conditions	<input type="checkbox"/>	Organic brain syndrome	<input type="checkbox"/>	Allergies:
<input type="checkbox"/>	Sugar or albumin in urine				Insert type(s)_____

For each of the conditions you have identified above, please provide the following information. If you cannot remember all of the details, please list as much information as you can. Attach additional pages if necessary.

Condition: \_\_\_\_\_

Name of doctor or facility: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment: \_\_\_\_\_

Medications: \_\_\_\_\_

Did the condition resolve? \_\_\_\_\_

Current status of the condition: \_\_\_\_\_

#### V. Family History

To the best of your knowledge, have any of your parents, grandparents, siblings, or children had any of the conditions listed above in section IV.F?

Family member	Cancer (including leukemias or lymphomas)? If "yes," provide the type and date of diagnosis	Disorders/conditions/diseases? If "yes," provide the type and date of diagnosis	Date of birth	Date of death
Mother				
Father				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				
Siblings				
Aunts/Uncles/Cousins				

VI. Physical Injuries, Illness and Damages

A. Please describe the LATER-MANIFESTED PHYSICAL CONDITION you claim.

1. Nature of physical injuries or illness: \_\_\_\_\_  
\_\_\_\_\_

2. The date that you first developed symptoms of the physical injuries or illness: \_\_\_\_\_

3. How you first became aware of the symptoms of the physical injuries or illness: \_\_\_\_\_  
\_\_\_\_\_

4. Whether those injuries or illnesses are continuing: \_\_\_\_\_

5. Please complete the following for the doctor or other healthcare provider who first diagnosed the physical injury or illness above.

a. Name: \_\_\_\_\_

b. Address: \_\_\_\_\_

c. Date of first consultation with that healthcare provider: \_\_\_\_\_

d. Date of last consultation: \_\_\_\_\_

e. Do you plan to continue to consult with that healthcare provider?

Yes     No

6. Did you see any other doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

Yes     No

If "yes," please complete the following for each healthcare provider:

a. Name: \_\_\_\_\_

b. Address: \_\_\_\_\_

c. Date of first consultation with that healthcare provider: \_\_\_\_\_

d. Date of last consultation: \_\_\_\_\_

e. Do you plan to continue to consult with that healthcare provider?

Yes     No

*section continues on next page*

**B.** Have you had any discussions with any doctor or other healthcare provider about whether oil, other hydrocarbons, or other substances released from the MC252 WELL and/or the *Deepwater Horizon* and its appurtenances, and/or dispersants or decontaminants used in connection with the RESPONSE ACTIVITIES contributed to your physical injuries or illness?

Yes     No

If "yes," provide the doctor's or healthcare provider's name and address, and the date of that discussion.

---

---

---

**VII. Extent And Duration of Exposure to Oil, Other Hydrocarbons, Or Other Substances Released From The MC252 WELL And/Or The *Deepwater Horizon* And Its Appurtenances, And/Or Dispersants Or Decontaminants Used In Connection With The RESPONSE ACTIVITIES**

**A.** Please specifically describe the circumstances and duration of your exposure to oil, other hydrocarbons, or other substances released from the MC252 WELL and/or the *Deepwater Horizon* and its appurtenances, and/or dispersants and/or decontaminants used in connection with the RESPONSE ACTIVITIES (use specific dates, locations, and activities):

---

---

---

**B.** For claims related to your role as a CLEAN-UP WORKER, include your role in the clean-up activities, the name of your employer, and where you were working:

---

---

---

**VIII. Documents**

Please provide a copy of all of your documents and things which fall into the categories listed below.

1. Signed HIPAA authorizations for the release of your medical records (Appendix B).
2. Signed authorizations for the release of your employment records (Appendix C).
3. A copy of any medical records in your possession that you wish to be considered from any physician, hospital, clinic, healthcare provider or pharmacy that treated you, or filled your prescriptions.
4. If you have been the claimant or subject of any worker's compensation, Social Security, or other disability proceeding, all documents relating to such proceeding.
5. Decedent's death certificate (if applicable) and the results of any post-mortem examination (if applicable).

## IX. Declaration

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

You may complete this form online via the Medical Benefits Settlement Web Portal at [www.deepwaterhorizonmedicalsettlement.com](http://www.deepwaterhorizonmedicalsettlement.com), but you must print it out in its entirety and return the signed form, the information of the AUTHORIZED REPRESENTATIVE, if any, and the employment records authorizations at Appendix B, and any records or other materials in support of your claim to:

**DEEPWATER HORIZON MEDICAL BENEFITS  
CLAIMS ADMINISTRATOR**  
600 Vine Street, Suite 2006  
Cincinnati, OH 45202

**MEDIATION INFORMATION FORM - Appendix A  
AUTHORIZED REPRESENTATIVES**

Complete this Appendix only if you are an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, and the information has changed since you submitted your NOTICE OF INTENT TO SUE.

A. Check all that apply for the MEDICAL BENEFITS SETTLEMENT CLASS MEMBER 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 \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

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 of the MEDIATION INFORMATION FORM. AUTHORIZED REPRESENTATIVES of a deceased person must also provide a copy of the death certificate.

\_\_\_\_\_  
\_\_\_\_\_



**MEDIATION INFORMATION FORM - Appendix B**

**HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508**

When submitting a **MEDIATION INFORMATION FORM**, you must also complete and submit this authorization. Submitting this form authorizes BP, subject to the terms of the **MEDICAL SETTLEMENT AGREEMENT**, to collect medical records from a **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER'S** healthcare providers. The information obtained from your healthcare providers pursuant to this authorization will be used by BP and a mediator in evaluating and mediating your claim for a **LATER-MANIFESTED PHYSICAL CONDITION** and in a **BACK-END LITIGATION OPTION LAWSUIT**. BP will promptly provide you a copy of the records it obtains pursuant to this authorization without cost to you.

Please fill out the fields and sign the document below. If you are an **AUTHORIZED REPRESENTATIVE** of a minor, incapacitated or incompetent person, or deceased person, please provide information for that person and sign below.

The capitalized terms in this form are defined in the **MEDICAL BENEFITS CLASS CLASS SETTLEMENT AGREEMENT**, which is available at [www.deepwaterhorizonmedicalsettlement.com](http://www.deepwaterhorizonmedicalsettlement.com) or by calling toll free 1-877-545-5111.

**You should keep a copy of anything submitted to the CLAIMS ADMINISTRATOR.**

**HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508**

NAME OF MEDICAL BENEFITS SETTLEMENT CLASS MEMBER

First Name	M.I.	Last Name

Date of Birth (mm/dd/yyyy)	Social Security Number

I, the **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** named above, hereby authorize my health care provider(s), health plan(s), and health insurer(s) to disclose my health records to BP through its counsel, the law firm of Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA 70139-5099 (hereafter referred to as "**Recipient**"), for the purpose of the evaluation and mediation of my claim for a LATER-MANIFESTED PHYSICAL CONDITION, including the submission of my health records to a mediator.

I hereby grant any reimbursement claim, lien holder or state or federal agency, and the contract representatives of either, permission to share with the **Recipient** all reimbursement claim and lien information and confirming **health records** regarding any conditional payments made, or medical care performed, by the claim / lien holder relating to LATER-MANIFESTED PHYSICAL CONDITIONS within the meaning of the MEDICAL BENEFITS CLASS ACTION SETTLEMENT (collectively referred to as "**lien information**").

As referred to above, my **health records** include any and all of the following:

Records of my medical condition(s), diagnoses, and treatment, including, but not limited to, physician’s records; surgeons’ records; discharge summaries; progress notes; consultations; pharmaceutical records; medication sheets; patient information sheets; consents for treatment; medical reports; x-rays and x-ray reports; CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films; interpretations of diagnostic tests; pathology materials, slides, tissues, and laboratory results and/or reports; consultations; physical therapy records; drug and/or alcohol abuse records; HIV/AIDS diagnosis and/or treatment; physicals and histories; correspondence; psychiatric records; psychological records; psychometric test results; social worker’s records; other

information pertaining to the physical and mental condition; all hospital summaries and hospital records including, but not limited to, admitting records; admitting histories and physicals; case records, discharge summaries; physician's orders, progress notes, and nurses' notes; medical record summaries; emergency room records; all other hospital documents and memoranda pertaining to any and all hospitalizations and/or out-patient visits; and

Any and all insurance records; statements of account, bills or billing records, or invoices; any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, or diagnosis pertaining to my health.

I understand that the information in my **health records** may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I wish to revoke the authorization, I must do so in writing and must provide my written revocation to any and all of my health care providers, health plans, or health insurers, state or federal agencies and all other third party lien holders to which the revocation will apply. I understand that the revocation will not apply to any disclosures that have already been made in reliance on this authorization prior to the date upon which the disclosing health care provider, health plan, health insurer, or such other third party receives my written revocation.

I understand that my authorization of the disclosure of my **health records** and **lien information** is voluntary and that I therefore can refuse to sign this authorization. I also understand that I do not need to sign this authorization in order to obtain health treatment or to receive or be eligible to receive benefits for coverage of health treatment.

I understand that, once disclosed to the **Recipient**, my **health records** and **lien information** may not be protected by federal privacy law and could be further disclosed to others without my authorization.

This authorization expires upon final resolution of my claim for a LATER-MANIFESTED PHYSICAL CONDITION in the Medical Benefits Class Action Settlement in MDL 2179.

I have a right to receive and retain a copy of this authorization when signed below.

---

Name of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER**  
(print)

---

Signature

---

Date

**OR**

---

Name and title of AUTHORIZED REPRESENTATIVE authorized to act on behalf of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** as:

---

Signature

---

Date

---

Relationship to **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER**

**MEDIATION INFORMATION FORM - Appendix C**  
**Authorization And Direction For Disclosure And Release Of Employee/Personnel Records**

**When submitting a MEDIATION INFORMATION FORM, you must also complete and submit this authorization. Submitting this form authorizes BP, subject to the terms of the MEDICAL SETTLEMENT AGREEMENT, to collect employment and personnel records from your past and present employers. The information obtained pursuant to this authorization will be used by BP and a mediator in evaluating and mediating your claim for a LATER-MANIFESTED PHYSICAL CONDITION and in a BACK-END LITIGATION OPTION LAWSUIT.**

**Please fill out the fields and sign the document below. If you are an AUTHORIZED REPRESENTATIVE of a minor, incapacitated or incompetent person, or deceased person, please provide information for that person and sign below.**

The capitalized terms in this form are defined in the MEDICAL SETTLEMENT AGREEMENT, which is available at [www.deepwaterhorizonmedicalsettlement.com](http://www.deepwaterhorizonmedicalsettlement.com) or by calling toll free 1-877-545-5111.

**You should retain a copy of anything submitted to the CLAIMS ADMINISTRATOR.**

**Authorization And Direction For Disclosure And Release Of Employee/Personnel Records**

**EMPLOYER:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**EMPLOYEE:**

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security No:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

I, the **EMPLOYEE** named above, do hereby **AUTHORIZE AND DIRECT** my past or current **EMPLOYER** identified above to disclose and release to BP through its counsel, the law firm of Liskow & Lewis, One Shell Square, 701 Poydras Street, Suite 5000, New Orleans, LA 70139-5099, and/or its duly authorized representative any and all records, files, documents and other information concerning my employment with the above-named **EMPLOYER**.

This authorization expires upon a final resolution of my claim for a LATER-MANIFESTED PHYSICAL CONDITION in the MEDICAL BENEFITS CLASS ACTION SETTLEMENT in MDL 2179.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
Printed **Employee** Name

\_\_\_\_\_  
**Employee** Signature

To be filled out by an Authorized Representative for an **Employee** who is a minor, incapacitated or incompetent person, or deceased person:

\_\_\_\_\_  
Name of AUTHORIZED REPRESENTATIVE authorized to act on **Employee's** behalf

\_\_\_\_\_  
Signature of AUTHORIZED REPRESENTATIVE authorized to act on **Employee's** behalf

\_\_\_\_\_  
Relationship to **Employee**