

MEDICAL BENEFITS CLASS ACTION SETTLEMENT
NOTICE OF INTENT TO SUE

Complete this form if you are a **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** seeking to exercise a **BACK-END LITIGATION OPTION**. In addition to this form, you must also submit the **HIPAA authorization (Appendix B)**, **Authorization and Release of Employee/Personnel Records (Appendix C)**, and either the **PHYSICIAN'S CERTIFICATION FORM (Appendix D)** or **medical records containing the diagnosis and date of first diagnosis of your LATER-MANIFESTED PHYSICAL CONDITION**. This form and all accompanying materials must be submitted to the **CLAIMS ADMINISTRATOR**, within 4 years after the date of first diagnosis of your **LATER-MANIFESTED PHYSICAL CONDITION** or the **EFFECTIVE DATE**, whichever is later. Unless otherwise specified, the information requested for a **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER ("You")** refers to the person who:

(1) worked as a CLEAN-UP WORKER between April 20, 2010, and April 16, 2012;

(2) resided in ZONE A for some time on each of at least 60 days between April 20, 2010, and September 30, 2010 ("ZONE A RESIDENT"), and who developed one or more SPECIFIED PHYSICAL CONDITIONS between April 20, 2010, and September 30, 2010; and/or

(3) resided in ZONE B for some time on each of at least 60 days between April 20, 2010 and December 31, 2010 ("ZONE B RESIDENT").

Within 10 days of the **CLAIMS ADMINISTRATOR's** receipt of a compliant Notice of Intent to Sue and the accompanying material described above, the **CLAIMS ADMINISTRATOR** will forward this form and the accompanying material to all **BP** defendants named in your **NOTICE OF INTENT TO SUE**. Within 30 days of receipt of this form and accompanying material, a **BP** defendant may exercise the option to mediate your claim(s). If a **BP** defendant decides to mediate your claim(s), you may not file a **BACK-END LITIGATION OPTION LAWSUIT** against **BP** or **OTHER RELEASED PARTIES** unless you complete the mediation process without resolving your claim(s). If a **BP** defendant does not choose to mediate your claim(s), you may file a **BACK-END LITIGATION OPTION LAWSUIT** against **BP** within 6 months after the **CLAIMS ADMINISTRATOR** notifies you that no **BP** defendant has chosen to mediate your claim(s).

If you are an **AUTHORIZED REPRESENTATIVE** making a claim on behalf of a person who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, please provide the information requested for the person for whom you are exercising a **BACK-END LITIGATION OPTION**, and also submit Appendix A and the requested materials.

Print or type all responses. 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.

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

D. Proof of Residence in ZONE A and/or ZONE B

Any claim submitted without sufficient proof of residence will be denied.

1. If you claim residence in ZONE A or ZONE B you must provide documentary proof of your residency, including the location and duration of your residence, between April 20, 2010, and September 30, 2010, for ZONE A, or April 20, 2010, and December 31, 2010, for ZONE B. To establish the fact of your residency, you must provide one or more of the following listed below. To establish the duration of your residence, you should provide one or more of the following listed below, but if no documentary proof of the duration of residency is available, you may provide a declaration signed under penalty of perjury to demonstrate the duration of your residency. Please check one or more of the following that you are submitting:

- A copy of a lease or title to property
- Utility or phone bills
- 1099 forms
- A driver's license or other government-issued ID
- Similar documentation
- Declaration (which may only be sufficient to establish your duration of residency)

2. A person who is (1) a minor, or (2) lacking capacity or incompetent, and claiming residency in ZONE A and/or ZONE B may also establish the fact, location, and duration of his or her residency through (1) school records, custody orders, medical records, and/or similar evidence; or (2) if such documentation does not exist, a written declaration of his or her AUTHORIZED REPRESENTATIVE signed under penalty of perjury and corroborated by contemporaneous documentary proof. Are you submitting either records or a declaration as described in this paragraph?

- Yes No

VI. Identification of LATER-MANIFESTED PHYSICAL CONDITIONS

- A.** Provide the following information about every LATER-MANIFESTED PHYSICAL CONDITION for which you are making a claim. Provide additional copies of this section as necessary to describe each condition.

1. Name/Description of LATER-MANIFESTED PHYSICAL CONDITION and symptoms thereof:
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2. Date on which the condition was first diagnosed: ____ / ____ / ____

B. Proof of LATER-MANIFESTED PHYSICAL CONDITION

You must establish the existence of the LATER-MANIFESTED PHYSICAL CONDITION claimed above by submitting with this form either (1) a PHYSICIAN'S CERTIFICATION FORM (Appendix D) or (2) medical records containing the diagnosis and date of first diagnosis of the LATER-MANIFESTED PHYSICAL CONDITION.

Please identify which of the following you are submitting with this form (check all that apply):

- PHYSICIAN'S CERTIFICATION FORM.
- Medical records containing the diagnosis and date of first diagnosis of the LATER-MANIFESTED PHYSICAL CONDITION you are claiming.

C. Workers' Compensation and Longshore and Harbor Workers' Compensation Act

1. Have you made a claim for benefits under a Workers' Compensation law or the Longshore and Harbor Workers' Compensation Act for any conditions related to your LATER-MANIFESTED PHYSICAL CONDITION at any time since April 16, 2012?

Yes No

2. If "yes", did you receive benefits under a Workers' Compensation law or the Longshore and Harbor Workers' Compensation Act?

Yes No

Identify the injury you suffered: _____

Identify the following:

Name of Employer or State Workers' Compensation Fund that provided your benefits under a Workers' Compensation law or the Longshore and Harbor Workers' Compensation Act?

Employer's State: _____

Workers' Comp Board Number: _____

Workers' Comp Carrier Name: _____

Workers' Comp Carrier ID: _____

VII. Identification of BP Defendants

Identify all of the BP defendants from whom you are seeking, or intend to seek, compensation for your LATER-MANIFESTED PHYSICAL CONDITION.

VIII. Medicare, Medicaid, and Other Lien, Indemnity, Subrogation and Other Interests Information

A. Medicare

1. Are you now, or have you been enrolled at any time since April 16, 2012, in Medicare?

Yes No

If yes, please provide your HICN (Medicare Claim #): _____

If yes, please provide your enrollment date: _____ / _____ / _____

Section continues on next page

2. Are you now, or have you been enrolled at any time since April 16, 2012, in a Medicare Advantage, Medicare Cost or similar Medicare replacement Plan and whom you believe or suspect may hold or assert any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type in connection with your LATER-MANIFESTED PHYSICAL CONDITION?

Yes No

If "yes", what is the name of such Medicare Advantage, Medicare Cost or similar Replacement Plan?

If "yes", please provide your member number for each such Plan:

If "yes", please provide your enrollment date:

____ / ____ / _____

3. Are you now, or have you been enrolled at any time since April 16, 2012, in a separate Medicare Plan D (prescription drug benefits) Plan and whom you believe or suspect may hold or assert any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type in connection with your LATER-MANIFESTED PHYSICAL CONDITION?

Yes No

If "yes", what is the name and your member number of each such Medicare Part D Plan?

B. Medicaid

1. Are you currently enrolled in a state Medicaid program?

Yes No

If yes, please provide your Medicaid ID Number:

State of Issuance:

Date of Enrollment:

____ / ____ / _____

2. Have you been enrolled in any other state Medicaid Program at any time since April 16, 2012?

Yes No

If yes, please provide your Medicaid ID Number:

State of Issuance:

Date of Enrollment:

____ / ____ / _____

Name of Entity: _____

Policy Number: _____

Medical Condition Covered by Entity: _____

E. Lien and Subrogation Information

1. Has anyone (such as an attorney, health care provider, insurance company, or government entity) sent you a letter or form asserting or notifying you of his, her, or its right to be entitled to the compensation you may receive as a result of or in connection with any claim for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE.

Yes No

If "yes", please provide a copy of every such letter or form to the CLAIMS ADMINISTRATOR. If you do not have a copy of such letter or form, please describe in detail who sent you the form or letter and the contents of such letter or form:

2. Has anyone (such as an attorney, health care provider, insurance company, or government entity) sent you anything in writing or told you that he, she, or it is entitled to a share of any compensation you may receive for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE? Please provide a copy of all such correspondence to

Yes No

If "yes", please describe:

3. List any other known and/or suspected subrogation, indemnity, lien, claim, conditional payment reimbursement right or other actual or potential interest of any type that has been (or may be) asserted by any state, government body, employer, attorney, insurer, provider and/or any other person or entity that may be related to the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE. Please provide a copy of all such correspondence to the CLAIMS ADMINISTRATOR.

F. Bankruptcy Information

1. Have you filed for bankruptcy protection at any time since April 16, 2012?

Yes No

If "yes", please complete the following (for each bankruptcy filed):

Court (in which you filed for bankruptcy): _____

Case No: _____

Date bankruptcy was filed: _____

If closed, date bankruptcy was closed: _____

IX. Conditions for Submission of NOTICE OF INTENT TO SUE

- A.** Confidentiality. By signing below, I authorize disclosure of the information contained in this form and any other documents obtained in connection with my claim to such persons as may be reasonably necessary for purposes of participation in mediation, exercise of a BACK-END LITIGATION OPTION, and/or seeking compensation for a LATER-MANIFESTED PHYSICAL CONDITION, including, but not limited to, verifying all claims of medical injury and treatment, employment history, residency in ZONE A and/or ZONE B, and fulfilling any Medicare Secondary Payer Act and other reporting requirements.
- B.** Acknowledgement of Being Bound by the Terms of the MEDICAL SETTLEMENT AGREEMENT. In consideration of the obligations of BP under the MEDICAL SETTLEMENT AGREEMENT approved by the COURT, I, the undersigned MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, individually and for my predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity to the extent he, she or it is entitled to assert any claim on my behalf, and/or, if by virtue of my capacity as an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, whether as predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity, and in that capacity, hereby expressly acknowledge and agree that I, individually and for my predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity to the extent he, she or it is entitled to assert any claim on my behalf, and/or, if by virtue of my capacity as an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, whether as predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity, and in that capacity, am bound by the terms of the MEDICAL SETTLEMENT AGREEMENT, including, but not limited to, the release of all RELEASED CLAIMS, the release of any claim for punitive, multiple, or exemplary damages against BP and OTHER RELEASED PARTIES in Section XVI of the MEDICAL SETTLEMENT AGREEMENT, and the limitations on the right to sue in Section VIII of the MEDICAL SETTLEMENT AGREEMENT. Provided, however, that this Acknowledgement shall be void and of no effect if I am not a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER.
- C.** I acknowledge that this form is an official court document sanctioned by the COURT that presides over the class actions arising from the *DEEPWATER HORIZON* INCIDENT, and submitting this document to the CLAIMS ADMINISTRATOR is equivalent to filing it with the COURT. 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. I agree to cooperate with the CLAIMS ADMINISTRATOR and to provide any necessary authorization for compliance with the Medicare Secondary Payer Act and other similar reporting requirements. I also understand that if the CLAIMS ADMINISTRATOR at any time has reason to believe that I have made an intentional misrepresentation, omission, and/or concealment of a material fact in this NOTICE OF INTENT TO SUE or have provided fraudulent proof in support of my claim, the CLAIMS ADMINISTRATOR will report the alleged intentional misrepresentation, omission, and/or concealment of a material fact and/or alleged fraudulent proof to the COURT, the United States Attorney's Office, the MEDICAL BENEFITS CLASS COUNSEL and BP'S COUNSEL, and that I may be subject to contempt of court or other lawful penalties, and that BP may elect not to participate in mediation.
- D.** I hereby certify that I have not filed and will not file a claim for benefits under Workers' Compensation law or the Longshore and Harbor Workers' Compensation Act for the LATER-MANIFESTED PHYSICAL CONDITION(S) being claimed in this NOTICE OF INTENT TO SUE.

If you are an AUTHORIZED REPRESENTATIVE, the terms above apply to you in your representative capacity and the MEDICAL BENEFITS SETTLEMENT CLASS MEMBER whom you represent.

Section continues on next page

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 applicable)

Date: ____ / ____ / ____

(Signature(s) of Counsel)

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, and any additional records or materials in support of your claim, to:

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

NOTICE OF INTENT TO SUE - 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 NOTICE OF INTENT TO SUE, you must also complete and submit this authorization. Submitting this form authorizes the CLAIMS ADMINISTRATOR, subject to the terms of the MEDICAL SETTLEMENT AGREEMENT, to use the information obtained from a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER'S healthcare providers to fulfill Medicare Secondary Payer Act and other reporting requirements.

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 or by calling toll free 1-877-545-5111.

You should retain a copy of anything you submit to the CLAIMS ADMINISTRATOR.

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 two years after a 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
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OR

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

NOTICE OF INTENT TO SUE FORM - Appendix C

**Authorization and Release of Employee/Personnel Records
(For CLEAN-UP WORKERS Without Sufficient Information In The Databases Or
Documentation Provided By BP To The CLAIMS ADMINISTRATOR)**

When submitting a NOTICE OF INTENT TO SUE, each CLEAN-UP WORKER who is not in one of the databases or documentation provided by BP to the CLAIMS ADMINISTRATOR pursuant to Section XXI.B of the MEDICAL SETTLEMENT AGREEMENT must also complete and submit this authorization. If you are unsure whether you are in such a database or documentation, you may contact the CLAIMS ADMINISTRATOR toll free at 1-877-545-5111 or by visiting the website www.deepwaterhorizonmedicalsettlement.com. The CLAIMS ADMINISTRATOR will respond to you promptly in writing.

Submitting this form authorizes the CLAIMS ADMINISTRATOR, 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 the CLAIMS ADMINISTRATOR for performing its duties pursuant to the MEDICAL SETTLEMENT AGREEMENT, including determining whether you qualify as a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER, fulfilling Medicare Secondary Payer Act and other reporting requirements, and identifying and resolving applicable liens.

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 or by calling toll free 1-877-545-5111.

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

**Authorization and Release of Employee/Personnel Records
(For CLEAN-UP WORKERS Without Sufficient Information In The Databases Or
Documentation Provided By BP To The CLAIMS ADMINISTRATOR)**

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 the CLAIMS ADMINISTRATOR of the MEDICAL BENEFITS SETTLEMENT CLASS SETTLEMENT, **Deepwater Horizon Medical Benefits Claims Administrator**, 600 Vine Street, Suite 2006, Cincinnati, OH 45202, 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 one year after the final determination by the CLAIMS ADMINISTRATOR regarding my eligibility for any benefits as a member of the MEDICAL BENEFITS SETTLEMENT CLASS in the MEDICAL BENEFITS CLASS ACTION SETTLEMENT in MDL 2179.

Dated this _____ day of _____ 201____.

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**

**NOTICE OF INTENT TO SUE - Appendix D
PHYSICIAN'S CERTIFICATION FORM**

This form is for use in connection with your NOTICE OF INTENT TO SUE. If you choose to submit this form, have your licensed physician complete and sign this form, and return it to you. You should submit the original of this form together with your NOTICE OF INTENT TO SUE.

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, the undersigned physician, declare under penalty of perjury that I have personally examined the person listed below and that I diagnosed him or her with the medical condition(s), and on the date(s), that I have identified in the chart below.

Name of Class Member

<i>Condition:</i>	<i>Date of Diagnosis:</i>
<i>Condition:</i>	<i>Date of Diagnosis:</i>
<i>Condition:</i>	<i>Date of Diagnosis:</i>

Physician's Name: _____

Address: _____

Telephone Number: _____

License Number / State: _____

Signature of Licensed Physician

Date