OPT OUT REVOCATION REQUEST

NAME OF POTENTIAL CLASS MEMBER: ____

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP CODE: ____________

PHONE: ______________________

DATE OF BIRTH: ______________________

SOCIAL SECURITY NUMBER (Optional): ______________________

GCCF ID (Optional): ______________________

MEDICAL BENEFITS CLAIM NUMBER (Optional): ______________________

ATTORNEY (Optional): ______________________

I wish to revoke my request to opt out of the Medical Benefits Settlement Class. By revoking my opt out request, I hereby withdraw and waive any and all current and future objections that I may have to the Medical Benefits Class Action Settlement.

____
Printed Name of Potential Class Member
(or Authorized Representative)

____
Signature of Potential Class Member
(or Authorized Representative)

____
Date