MEDICAL BENEFITS CLASS ACTION SETTLEMENT REQUEST FOR REVIEW FORM

Complete this form and submit it to the CLAIMS ADMINISTRATOR (at the address at the end of the form) if you think the CLAIMS ADMINISTRATOR erred in its determination of your claim and want to request a one-time review.

NOTE THAT IN ORDER TO RECEIVE A ONE-TIME REVIEW OF THE CLAIMS ADMINISTRATOR'S DETERMINATION, YOU MUST SUBMIT THIS FORM WITHIN 14 DAYS OF RECEIPT OF THE CLAIMS ADMINISTRATOR'S DETERMINATION.

The one-time review will be completed within 14 days of the CLAIMS ADMINISTRATOR'S receipt of your completed REQUEST FOR REVIEW FORM, and the reviewer's determination will be final and not appealable. The reviewer will only overturn the denial of your claim where he or she finds that such denial was based on a clearly erroneous factual determination by the CLAIMS ADMINISTRATOR.

This form must be signed personally by the person making the request, or in the case of a person who is (1) a minor, (2) lacks capacity or is incompetent, or (3) deceased, by his or her AUTHORIZED REPRESENTATIVE. If you are an AUTHORIZED REPRESENTATIVE, please provide the information in this form for the person you represent (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.

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

Contact Information (of the person who filed the claim).

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Cla	aima	nt ID	Nur	nbe	r																
Fir	First Name M.I. Last Name																				
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Cit	ty															Stat	e 	Zip	Code	e 	

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Cellular Number E-mail Address Date of Birth (MM/DD/YYYY)	Telephone Number (Daytime) Telephone Number (Evening) Telephone Number (Evening)												
Date of Birth (MM/DD/YYYY)	Cellular Number												
Gender Male Female II. Representation by Legal Counsel Are you represented by any lawyer in connection with your claim? Yes No If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name Law Firm's Street Address City State Zip Code	E-mail Address												
II. Representation by Legal Counsel Are you represented by any lawyer in connection with your claim? Yes No If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name City State Zip Code	Date of Birth (MM/DD/YYYY)												
II. Representation by Legal Counsel Are you represented by any lawyer in connection with your claim? Yes No If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name City Street Address	Gender												
Are you represented by any lawyer in connection with your claim? Yes No If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name City Street Address City State Zip Code	Male Female												
Are you represented by any lawyer in connection with your claim? Yes No If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name City Street Address City State Zip Code													
If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name City State Zip Code	II. Representation by Legal Counsel												
If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name Law Firm's Street Address City State Zip Code	Are you represented by any lawyer in connection with your claim?												
If "yes," please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for review will be made to your lawyer): Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name Law Firm's Street Address City State Zip Code	Yes No												
Lawyer's First Name M.I. Lawyer's Last Name Law Firm's Name Law Firm's Street Address City State Zip Code													
Law Firm's Name Law Firm's Street Address City State Zip Code													
Law Firm's Street Address City State Zip Code	Lawyer's First Name												
Law Firm's Street Address City State Zip Code	Law Eirm's Namo												
City State Zip Code													
City State Zip Code													
Telephone Number Fax Number —	City State Zip Code												
	Telephone Number Fax Number —												

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

Complete this section only if you are an AUTHORIZED REPRESENTATIVE completing this form on behalf of a person who is (1) a minor, (2) lacks capacity or is incompetent, or (3) is deceased.

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Α	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://																							
В.	B. Provide the following information about yourself (the AUTHORIZED REPRESENTATIVE filling out this form):																							
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Te	Telephone Number																							
E-1	E-mail Address																							
C.	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.																							
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IV.	IV. Reason for Review																							

State the reason that you believe the CLAIMS ADMINISTRATOR made a clearly erroneous factual determination. Attach additional documents if necessary. Please do <u>not</u> resubmit any documents already

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submitted to the CLAIMS ADMINISTRATOR; you records you have previously provided.	may, however, direct the CLAIMS ADMINISTRATOR to
-	
the DEEPWATER HORIZON INCIDENT. Submitting this d	ne COURT that presides over the class actions arising from ocument to the CLAIMS ADMINISTRATOR is equivalent to perjury that the information provided in this form is true and belief.
Signature of MEDICAL BENEFITS SETTLEMENT CLASS MEI	Date: / /
or	
Signature of AUTHORIZED REPRESENTATIVE, if any	// Date://
You may complete this form online via the Medical Bene www.deepwaterhorizonmedicalsettlement.com, but you form, and any additional records or materials in support	must print it out in its entirety and submit the signed
Epia Mass Tort	

Attn: **DWH** Medical Benefits Class Action Settlement

P.O. Box 3420

Portland, OR 97208-3420