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[illegible]

Male Female

II. Representation by Legal Counsel

☐ Yes ☐ No

If “yes”, please provide your lawyer’s name, law firm, and contact information (Please note that all communications about your challenge will be made to your lawyer):

[illegible][illegible][illegible]

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IV. Reason for Challenge

State the reason that you believe the CLAIMS ADMINISTRATOR erred in determining that you are not a member of the Medical Benefits Settlement Class. Please do not submit any documents with this CLASS MEMBERSHIP CHALLENGE FORM (other than the AUTHORIZED REPRESENTATIVE documents required to be submitted under Section III above, if applicable). You may, however, direct the CLAIMS ADMINISTRATOR to records you have previously provided.

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 any

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 to:

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