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.

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

Claimant ID Number

First Name M.I. Last Name

Any Other Names Used in the Last 10 Years

Current or Last Known Street Address

City State Zip Code

Section continues on next page

Telephone Number (Daytime)

Telephone Number (Evening)

Cellular Number

E-mail Address

Date of Birth (MM/DD/YYYY)

_____ / _____ / _____

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

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.

Section continues on next page

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: ____ / ____ / ____

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

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 above. AUTHORIZED REPRESENTATIVES of a deceased person must also provide a copy of the death certificate.

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 not resubmit any documents already

Section continues on next page

submitted to the CLAIMS ADMINISTRATOR; 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.

_____ Date: ____ / ____ / ____
Signature of MEDICAL BENEFITS SETTLEMENT CLASS MEMBER

or

_____ Date: ____ / ____ / ____
Signature of AUTHORIZED REPRESENTATIVE, if any

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 request, to:

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