EXHIBIT 1

MEDICAL BENEFITS CLASS ACTION SETTLEMENT
DATA DISCLOSURE FORM

Complete this form and submit it to the CLAIMS ADMINISTRATOR (at the address at the end of the form) if you think you may be a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER and want to request information that may be related to you from within the databases and documentation that BP provided to the CLAIMS ADMINISTRATOR, as described in the MEDICAL SETTLEMENT AGREEMENT. Such data may include, among other things, information, and/or records concerning the identification of persons who were CLEAN-UP WORKERS and/or who visited medic stations funded by BP for CLEAN-UP WORKERS.

This form must be signed personally by the person whose information is being requested, 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 requested for the person for whom you are submitting this form (unless otherwise directed).

The capitalized terms in this form are defined in the MEDICAL BENEFITS CLASS ACTION SETTLEMENT AGREEMENT, which is available at www.[ ].com or by calling toll free x-xxx-xxx-xxxx.

Attorneys may not sign this form on behalf of a client.

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

I. Contact Information (of the person whose information is being requested).

Claimant ID Number (if one has been assigned)

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

Telephone Number (Daytime) – – Telephone Number (Evening) – –

Cellular Number – –

Date of Birth (MM/DD/YYYY) / / Gender ☐ Male ☐ Female

SAMPLE

II. Representation by Legal Counsel

Are you represented by any lawyer in connection with this request? ☐ Yes ☐ No

If "yes", please provide your lawyer's name, law firm, and contact information (Please note that all communications about your request for data will be made to your lawyer):

Lawyer's First Name M.I. Lawyer's Last Name

Law Firm's Name

Lawyer's Street Address

City State Zip Code

Telephone Number – – Fax Number – –

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

Complete this section only if you are an AUTHORIZED REPRESENTATIVE of a person who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, and are seeking information on behalf of the such person.

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.

Firm Name

Section continues on next page

SAMPLE

Street Address

City State Zip Code

Telephone Number (Daytime)

– –

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. CERTIFICATION: I certify that I am the person identified above in Section I, or the AUTHORIZED REPRESENTATIVE for such person identified above in Section III. I hereby request and authorize the CLAIMS ADMINISTRATOR to provide me, or if represented, my counsel, with a copy of all information pertaining to me that was provided by BP to the CLAIMS ADMINISTRATOR pursuant to the MEDICAL SETTLEMENT AGREEMENT.

SAMPLE

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.

YOU MUST ATTACH A COPY OF YOUR DRIVER'S LICENSE OR OTHER GOVERNMENT-ISSUED IDENTIFICATION WHEN YOU SUBMIT THIS FORM TO THE CLAIMS ADMINISTRATOR.

_____ Date: ____ / ____ / ____
Signature of person requesting information

or

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

You may complete this form online via the Medical Benefits Settlement Web Portal at www.[ ].com, but you must print it out in its entirety and submit the signed form and a copy of your driver's license or other government-issued identification to:

DEEPWATER HORIZON MEDICAL BENEFITS
CLAIMS ADMINISTRATOR
[Insert Claims Administrator Mailing Address]

SAMPLE