EXHIBIT 4

MEDICAL BENEFITS CLASS ACTION SETTLEMENT
NOTICE OF INTENT TO SUE

Complete this form if you are a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER seeking to exercise a BACK-END LITIGATION OPTION. In addition to this form, you must also submit the HIPAA authorization (Appendix B), and either the PHYSICIAN'S CERTIFICATION FORM (Appendix C) or medical records containing the diagnosis and date of first diagnosis of your LATER-MANIFESTED PHYSICAL CONDITION. This form and all accompanying materials must be submitted to the CLAIMS ADMINISTRATOR, within 4 years after the date of first diagnosis of your LATER-MANIFESTED PHYSICAL CONDITION or the EFFECTIVE DATE, whichever is later.

Within 10 days of the CLAIMS ADMINISTRATOR's receipt of this form and the accompanying material described above, the CLAIMS ADMINISTRATOR will forward this form and the accompanying material to all BP defendants named in your NOTICE OF INTENT TO SUE. Within 30 days of receipt of this form and accompanying material, a BP defendant may exercise the option to mediate your claim(s). If a BP defendant decides to mediate your claim(s), you may not file a BACK-END LITIGATION OPTION LAWSUIT against BP or OTHER RELEASED PARTIES unless you complete the mediation process without resolving your claim(s). If a BP defendant does not choose to mediate your claim(s), you may file a BACK-END LITIGATION OPTION LAWSUIT against BP within 6 months after the CLAIMS ADMINISTRATOR notifies you that no BP defendant has chosen to mediate your claim(s).

If you are an AUTHORIZED REPRESENTATIVE making a claim on behalf of a person who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased, please provide the information requested for the person for whom you are exercising a BACK-END LITIGATION OPTION, and also submit Appendix A and the requested materials.

Print or type all responses. In completing this form, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you are represented by counsel, you may and should consult with your attorney if you have any questions regarding the completion of this form.

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

You should submit all your materials together. You should retain a copy of everything submitted to the CLAIMS ADMINISTRATOR.

I. Personal & Background Information

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 - -

E-mail address (if any)

Date of birth (mm/dd/yyyy) / /

Social security number - -

Driver's license number / Other state ID | State

Gender ☐ Male ☐ Female

How should the CLAIMS ADMINISTRATOR communicate with you in connection with your claim?

☐ Mail ☐ E-mail ☐ Telephone

II. Representation by Legal Counsel

Are you represented by any lawyer in connection with this claim?

☐ Yes ☐ No

If "yes", please provide your lawyer's name, law firm, and contact information (Please note that all communications 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

Section continues on next page

City | State | Zip Code

Telephone Number | Fax Number

Lawyer's E-mail Address

III. Basis for Participation in MEDICAL BENEFITS CLASS ACTION SETTLEMENT

Which of the following is the basis for your participation in this class settlement? Check every box that you think applies. If none of the following apply to you, you are not eligible to participate in this settlement.

☐ I was a CLEAN-UP WORKER at any time between April 20, 2010, and April 16, 2012.

☐ I resided in ZONE A for some time on each of at least 60 days between April 20, 2010, and September 30, 2010 and developed one or more SPECIFIED PHYSICAL CONDITIONS within the timeframes set forth on the SPECIFIED PHYSICAL CONDITIONS MATRIX.

☐ I resided in ZONE B for some time on each of at least 60 days between April 20, 2010, and December 31, 2010.

IV. Identification of LATER-MANIFESTED PHYSICAL CONDITIONS

A. Provide the following information about every LATER-MANIFESTED PHYSICAL CONDITION for which you are making a claim. Provide additional copies of this section as necessary to describe any additional conditions.

1. Name/Description of LATER-MANIFESTED PHYSICAL CONDITION and symptoms thereof:

_____

_____

2. Date on which the condition was first diagnosed: _____ / _____ / _____

B. Proof of LATER-MANIFESTED PHYSICAL CONDITION

You must establish the existence of the LATER-MANIFESTED PHYSICAL CONDITION claimed above by submitting with this form either (1) a PHYSICIAN'S CERTIFICATION FORM (Appendix C) or (2) medical records containing the diagnosis and date of first diagnosis of the LATER-MANIFESTED PHYSICAL CONDITION.

Section continues on next page

Please identify which of the following you are submitting with this form (check all that apply):

☐ PHYSICIAN'S CERTIFICATION FORM.

☐ Medical records containing the diagnosis and date of first diagnosis of the LATER-MANIFESTED PHYSICAL CONDITION you are claiming.

V. Identification of BP Defendants

Identify all of the BP defendants from whom you are seeking, or intend to seek, compensation for your LATER-MANIFESTED PHYSICAL CONDITION.

VI. Medicare, Medicaid, and Other Lien, Indemnity, Subrogation and Other Interests Information

A. Medicare

1. Are you now, or have you been enrolled at any time since April 16, 2012, in Medicare?

☐ Yes ☐ No

If yes, please provide your HICN (Medicare Claim #): _____

If yes, please provide your enrollment date: ____ / ____ / _____

2. Are you now, or have you been enrolled at any time since April 16, 2012, in a Medicare Advantage, Medicare Cost or similar Medicare replacement Plan and whom you believe or suspect may hold or assert any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type in connection with your LATER-MANIFESTED PHYSICAL CONDITION?

☐ Yes ☐ No

If "yes", what is the name of such Medicare Advantage, Medicare Cost or similar Replacement Plan?

If "yes", please provide your member number for each such Plan:

If "yes", please provide your enrollment date:

____ / ____ / _____

3. Are you now, or have you been enrolled at any time since April 16, 2012, in a separate Medicare Plan D (prescription drug benefits) Plan and whom you believe or suspect may hold or assert any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type in connection with your LATER-MANIFESTED PHYSICAL CONDITION?

☐ Yes ☐ No

If "yes", what is the name and your member number of each such Medicare Part D Plan?

Section continues on next page

B. Medicaid

1. Are you currently enrolled in a state Medicaid program?

☐ Yes ☐ No

If yes, please provide your Medicaid ID Number:

State of Issuance:

Date of Enrollment: / /

2. Have you been enrolled in any other state Medicaid Program at any time since April 16, 2012?

☐ Yes ☐ No

If yes, please provide your Medicaid ID Number:

State of Issuance:

Date of Enrollment: / /

C. Veterans Administration Benefits, TRICARE benefits, or INDIAN HEALTH SERVICES

1. Please check all of the following for which you have been entitled at any time since April 16, 2012, to receive:

☐ Veterans Administration health care or prescription drug benefits

☐ TRICARE healthcare or prescription drug benefits

☐ INDIAN HEALTH SERVICES health care or prescription drug benefits

2. If you checked any of the above, for each one you checked, please state:

A. Applicable Program

Claim Number

Dates of Enrollment

/ / to / /

Branch _____

Sponsor _____

Sponsor SSN - -

Treating Facility _____

Section continues on next page

D. Other Health Care Coverage

1. Were you entitled to receive, at any time since April 16, 2012, health care benefits or prescription drugs from any type of person or entity not previously listed in Section IV for injuries claimed to arise out of the *DEEPWATER HORIZON* INCIDENT and whom you believe or suspect may hold or assert any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type in connection with any claim for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE?

   ☐ Yes ☐ No

2. Has any insurer or other person or entity made any payment(s) on your behalf for any medical condition for which you are making with any claim for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE?

   ☐ Yes ☐ No

If "yes" to either question above, provide the following information for every such person or entity:

Name of Entity: _____

Policy Number: _____

Medical Condition Covered by Entity: _____

Name of Entity: _____

Policy Number: _____

Medical Condition Covered by Entity: _____

Name of Entity: _____

Policy Number: _____

Medical Condition Covered by Entity: _____

E. Workers' Compensation

1. Have you made a claim for workers' compensation benefits for any conditions related to your LATER-MANIFESTED PHYSICAL CONDITION at any time since April 16, 2012?

☐ Yes ☐ No

2. If "yes", did you receive workers' compensation benefits?

☐ Yes ☐ No

Identify the injury you suffered: _____

Identify the following:

Name of employer or state workers' compensation fund that provided your workers' compensation benefits?

Section continues on next page

Employer's State: _____

Workers' Comp Board Number: _____

Workers' Comp Carrier Name: _____

Workers' Comp Carrier ID: _____

F. Lien and Subrogation Information

1. Has anyone (such as an attorney, health care provider, insurance company, or government entity) sent you a letter or form asserting or notifying you of his, her, or its right to be entitled to the compensation you may receive as a result of or in connection with any claim for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE.

   ☐ Yes ☐ No

   If "yes", please provide a copy of every such letter or form to the CLAIMS ADMINISTRATOR. If you do not have a copy of such letter or form, please describe in detail who sent you the form or letter and the contents of such letter or form:

2. Has anyone (such as an attorney, health care provider, insurance company, or government entity) sent you anything in writing or told you that he, she, or it is entitled to a share of any compensation you may receive for the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE? Please provide a copy of all such correspondence to the CLAIMS ADMINISTRATOR.

   ☐ Yes ☐ No

   If "yes", please describe:

3. List any other known and/or suspected subrogation, indemnity, lien, claim, conditional payment reimbursement right or other actual or potential interest of any type that has been (or may be) asserted by any state, government body, employer, attorney, insurer, provider and/or any other person or entity that may be related to the LATER-MANIFESTED PHYSICAL CONDITION(S) being asserted in this NOTICE OF INTENT TO SUE. Please provide a copy of all such correspondence to the CLAIMS ADMINISTRATOR.

Section continues on next page

G. Bankruptcy Information

1. Have you filed for bankruptcy protection at any time since April 16, 2012?

☐ Yes ☐ No

If "yes", please complete the following (for each bankruptcy filed):

Court (in which you filed for bankruptcy): _____

Case No: _____

Date bankruptcy was filed: _____

If closed, date bankruptcy was closed: _____

VII. Conditions for Submission of NOTICE OF INTENT TO SUE

A. Confidentiality. By signing below, I authorize disclosure of the information contained in this form and any other documents obtained in connection with my claim to such persons as may be reasonably necessary for purposes of participation in mediation, exercise of a BACK-END LITIGATION OPTION, and/or seeking compensation for a LATER-MANIFESTED PHYSICAL CONDITION, including, but not limited to, verifying all claims of medical injury and treatment, employment history, residency in ZONE A and/or ZONE B, and fulfilling any Medicare Secondary Payer Act and other reporting requirements.

B. Acknowledgement of Being Bound by the Terms of the MEDICAL SETTLEMENT AGREEMENT. In consideration of the obligations of BP under the MEDICAL SETTLEMENT AGREEMENT approved by the COURT, I, the undersigned MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, individually and for my predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity to the extent he, she or it is entitled to assert any claim on my behalf, and/or, if by virtue of my capacity as an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, whether as predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity, and in that capacity, hereby expressly acknowledge and agree that I, individually and for my predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity to the extent he, she or it is entitled to assert any claim on my behalf, and/or, if by virtue of my capacity as an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS CLASS ACTION SETTLEMENT CLASS MEMBER, whether as predecessors, successors, assigns, representatives, attorneys, agents, trustees, insurers, heirs, beneficiaries, executors, administrators, and any natural, legal, or juridical person or entity, and in that capacity, am bound by the terms of the MEDICAL SETTLEMENT AGREEMENT, including, but not limited to, the release of all RELEASED CLAIMS, the release of any claim for punitive, multiple, or exemplary damages against BP and OTHER RELEASED PARTIES in Section XVI of the MEDICAL SETTLEMENT AGREEMENT, and the limitations on the right to sue in Section VIII of the MEDICAL SETTLEMENT AGREEMENT. Provided, however, that this Acknowledgement shall be void and of no effect if I am not a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER.

C. I acknowledge that this form is an official court document sanctioned by the COURT that presides over the class actions arising from the *DEEPWATER HORIZON* INCIDENT, and submitting this document to the CLAIMS ADMINISTRATOR is equivalent to filing it with the COURT. 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. I agree to cooperate with the CLAIMS ADMINISTRATOR and to provide any necessary authorization for compliance with the Medicare Secondary Payer Act and other similar reporting requirements. I also understand that if the CLAIMS ADMINISTRATOR at any time has reason to believe that I have made an intentional misrepresentation, omission, and/or concealment of a material fact in this NOTICE OF INTENT TO SUE or have provided fraudulent proof in support of my claim, the CLAIMS ADMINISTRATOR will report the alleged intentional misrepresentation, omission, and/or concealment

of a material fact and/or alleged fraudulent proof to the COURT, the United States Attorney's Office, the MEDICAL BENEFITS CLASS COUNSEL and BP'S COUNSEL, and that I may be subject to contempt of court or other lawful penalties, and that BP may elect not to participate in mediation.

D. I hereby certify that I have not filed and will not file a claim for benefits under worker's compensation law or the Longshore and Harbor Workers' Compensation Act for the LATER-MANIFESTED PHYSICAL CONDITION(S) being claimed in this NOTICE OF INTENT TO SUE.

If you are an AUTHORIZED REPRESENTATIVE, the terms above apply to you in your representative capacity and the MEDICAL BENEFITS SETTLEMENT CLASS MEMBER whom you represent.

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 applicable)

_____ Date: ____ / ____ / ____
(Signature(s) of Counsel)

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 any additional records or materials in support of your claim, to:

DEEPWATER HORIZON MEDICAL BENEFITS
CLAIMS ADMINISTRATOR
[INSERT CLAIMS ADMINISTRATOR MAILING ADDRESS]

NOTICE OF INTENT TO SUE - Appendix A
AUTHORIZED REPRESENTATIVES

Complete this Appendix only if you are an AUTHORIZED REPRESENTATIVE of a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER who is (1) a minor, (2) lacking capacity or incompetent, or (3) deceased.

A. Check all that apply for the MEDICAL BENEFITS SETTLEMENT CLASS MEMBER 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

Current Street Address

City State Zip Code

Telephone Number - - Fax 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 of the MEDIATION INFORMATION FORM. AUTHORIZED REPRESENTATIVES of a deceased person must also provide a copy of the death certificate.

NOTICE OF INTENT TO SUE - Appendix B
HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508

When submitting a NOTICE OF INTENT TO SUE, you must also complete and submit this authorization. Submitting this form authorizes the CLAIMS ADMINISTRATOR, subject to the terms of the MEDICAL SETTLEMENT AGREEMENT, to use the information obtained from a MEDICAL BENEFITS SETTLEMENT CLASS MEMBER'S healthcare providers to fulfill Medicare Secondary Payer Act and other reporting requirements.

Please fill out the fields and sign the document below. If you are an AUTHORIZED REPRESENTATIVE of a minor, incapacitated or incompetent person, or deceased person, please provide information for that person and sign below.

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

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

HIPAA Authorization for Disclosure of Medical Records and Disclosure of Protected Health Information Pursuant to 45 C.F.R. § 164-508

NAME OF MEDICAL BENEFITS SETTLEMENT CLASS MEMBER

First Name M.I. Last Name

Date of Birth (mm/dd/yyyy) Social Security Number

I, the **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** named above, hereby authorize my health care provider(s), health plan(s), and health insurer(s) to disclose my health records to the CLAIMS ADMINISTRATOR of the MEDICAL BENEFITS CLASS ACTION SETTLEMENT, [Insert Medical Claims Administrator name] [Insert Claims Administrator Mailing Address] (hereafter referred to as "**Recipient**"), for the purpose of verifying any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type I may owe for medical items, services, and/or prescription drugs I received relating to the LATER MANIFESTED PHYSICAL CONDITION with which I have been diagnosed.

I hereby grant any holder of any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type, or state or federal agency, and their contract representatives, permission to share with the **Recipient** all information related to any lien, claim, or right of subrogation, indemnity, reimbursement, conditional or other payment, or interest and confirming **health records** regarding any conditional or other payments made, or medical item, services, and/or prescription drugs provided, by the holder of such lien, claim, or right of subrogation, indemnity, reimbursement, conditional or other payment, or interest of any type relating to a LATER-MANIFESTED PHYSICAL CONDITION within the meaning of the MEDICAL BENEFITS CLASS ACTION SETTLEMENT (collectively referred to as "**lien information**").

As referred to above, my **health records** include any and all of the following:

Records of my medical condition(s), diagnoses, and treatment, including, but not limited to, physician's records; surgeons' records; discharge summaries; progress notes; consultations; pharmaceutical records; medication sheets; patient

information sheets; consents for treatment; medical reports; x-rays and x-ray reports; CT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films; interpretations of diagnostic tests; pathology materials, slides, tissues, and laboratory results and/or reports; consultations; physical therapy records; drug and/or alcohol abuse records; HIV/AIDS diagnosis and/or treatment; physicals and histories; correspondence; psychiatric records; psychological records; psychometric test results; social worker's records; other information pertaining to the physical and mental condition; all hospital summaries and hospital records including, but not limited to, admitting records; admitting histories and physicals; case records, discharge summaries; physician's orders, progress notes, and nurses' notes; medical record summaries; emergency room records; all other hospital documents and memoranda pertaining to any and all hospitalizations and/or out-patient visits; and

Any and all insurance records; statements of account, bills or billing records, or invoices; any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, or diagnosis pertaining to my health.

I understand that the information in my **health records** may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I wish to revoke the authorization, I must do so in writing and must provide my written revocation to any and all of my health care providers, health plans, or health insurers, state or federal agencies, and all other third party lien holders to which the revocation will apply. I understand that the revocation will not apply to any disclosures that have already been made in reliance on this authorization prior to the date upon which the disclosing health care provider, health plan, health insurer, or such other third party receives my written revocation.

I understand that my authorization of the disclosure of my **health records** and **lien information** is voluntary and that I therefore can refuse to sign this authorization. I also understand that I do not need to sign this authorization in order to obtain health treatment or to receive or be eligible to receive benefits for coverage of health treatment.

I understand that, once disclosed to the **Recipient**, my **health records** and **lien information** may not be protected by federal privacy law and could be further disclosed to others without my authorization.

This authorization expires two years after a final resolution of my claim for a LATER-MANIFESTED PHYSICAL CONDITION in the Medical Benefits Class Action Settlement in MDL 2179.

I have a right to receive and retain a copy of this authorization when signed below.

Name of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** (print)	Signature	Date
OR		
Name and title of AUTHORIZED REPRESENTATIVE authorized to act on behalf of **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER** as:	Signature	Date
Relationship to **MEDICAL BENEFITS SETTLEMENT CLASS MEMBER**		

NOTICE OF INTENT TO SUE - Appendix C
PHYSICIAN'S CERTIFICATION FORM

This form is for use in connection with your NOTICE OF INTENT TO SUE. If you choose to submit this form, have your licensed physician complete and sign this form, and return it to you. You should submit the original of this form together with your NOTICE OF INTENT TO SUE.

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

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

I, the undersigned physician, declare under penalty of perjury that I have personally examined the person listed below and that I diagnosed him or her with the medical condition(s), and on the date(s), that I have identified in the chart below.

_____
Name of Class Member

Condition:	*Date of Diagnosis:*
Condition:	*Date of Diagnosis:*
Condition:	*Date of Diagnosis:*

Physician's Name: _____

Address: _____

Telephone Number: _____

License Number / State: _____

_____ _____
Signature of Licensed Physician Date