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CLAIM FORM

This Claim Form is solely for **Settlement Class Members** who have suffered harm because of the release Incidents that took place at the Limetree Bay Refinery on February 4, 2021, April 23, 2021, May 5, 2021, and May 12, 2021. If you do not claim to have suffered harm because of those Incidents, then you should not fill out this Claim Form.

A **Settlement Class Member** is any person or entity: (a) who owned or rented property (real and/or personal) in the Affected Geographic Area on or after February 3, 2021; *or* (b) who resided in, worked in, owned or operated a business in, or were present in the Affected Geographic Area during the time period from February 3, 2021 to May 26, 2021.

*The term “Affected Geographic Area” means the western portion of the Island of St. Croix, more particularly described as bounded by 64.74 degrees West Longitude and the sea. A **Settlement Map** of the Affected Geographic Area is located on the Settlement Website, **www.LimetreeBaySettlement.com**, and is also available at the law offices listed below.

If you decide to fill out this Claim Form, please answer **all questions honestly and accurately**. You are attesting under penalty of perjury that all of your statements below are true and correct as if you were testifying in court.

Part I below is your Claimant Information.

Part II below seeks information about any **property damage, nuisance, trespass, economic losses, physical or emotional health manifestations, cistern related physical impact, and non-reimbursed out-of-pocket expenses** that you suffered arising from the Limetree Bay Refinery Incidents. Payments will be distributed based on a pro rata point system described in the **Claimant Payment Formula** posted on the Settlement Website and available at the following law offices:

Lee J. Rohn & Associates 56 King Street, Third Floor Hamilton House Christiansted, St. Croix, VI 00820 (340) 778-8855 info@rohnlaw.com	Colianni & Leonard 2120 Company Street, Christiansted, St. Croix, VI 00820 (340) 719-1766 mailbox@colianni.com	Dema Law 1236 Strand Street, Suite 103 Christiansted, St. Croix, VI 00820 (340) 773-6142 limetree-claims@demalaw.com
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Part III below seeks information about your preferred Form of Payment.

To complete this Claim Form, you must:

- (a) completely fill out Part I – Claimant Information;
- (b) completely fill out Part II, related to the damages that you claim you suffered;
- (c) completely fill out Part III, related to your form of Settlement Payment;
- (d) personally sign the certification and declaration in Part IV;
- (e) attach all documentation of your alleged harm as requested below; and
- (f) timely return your completed Claim Form and any requested documentation to the Settlement Administrator.

YOU MUST SUBMIT YOUR COMPLETED CLAIM FORM BY NOVEMBER 3, 2026 IN ORDER FOR IT TO BE CONSIDERED TIMELY.

You may fill out this Claim Form in hard copy or you may fill out the electronic Claim Form located at **www.LimetreeBaySettlement.com**. The electronic Claim Form can be filled out using the HIPAA-compliant portal located on the website. If you fill out the Claim Form in hard copy, you may return it by email to info@LimetreeBaySettlement.com or by mail to Limetree Bay Settlement Administrator, P.O. Box 2420, Portland, OR 97208-2420.

If you have any questions about this Claim Form, please email info@LimetreeBaySettlement.com or call the Settlement Administrator toll-free at 1-888-859-9973, or contact the Settlement Administrator using the Contact Us form located at **www.LimetreeBaySettlement.com**. For additional information about the Settlement, please visit **www.LimetreeBaySettlement.com**.

***Unique ID and PIN.** Your Unique ID and PIN are located on the first page of the Notice of Settlement that you received. If you are unsure whether you have a Unique ID and PIN, contact the Settlement Administrator to check.

If you submit a Claim Form **without** a Unique ID and PIN, **you must** submit documentary proof of identification, such as a driver's license, lease, mortgage, utility bill, credit card statement, deed, pay stub, insurance bill, or court document (including a citation listing your address).

PART II – DAMAGES CLAIMED

If you claim to have suffered **property damage, nuisance, trespass, economic losses, physical health or emotional manifestations, cistern related physical impact, and/or non-reimbursed out-of-pocket expenses** arising from the release Incidents from the Limetree Bay Refinery from February to May 2021, you may be eligible to receive a monetary award based upon your answers to the questions below. **Please carefully review and answer each question below.** Each answer you provide below is submitted under penalty of perjury as if you were testifying in court.

ANSWER EACH QUESTION BELOW

1. Did you suffer **damage to your property**, whether a structure, a cistern, a car, or any other property, because of the release Incidents from the Limetree Bay Refinery?*

☐ Yes ☐ No

*Please note that under the Claimant Payment Formula, property damage points will be accumulated for each separate property as to which the Claimant can support a claim. But, as to any particular property, only one claim may be made for any owner and one claim for any renter. In the situation of fractional ownership or rental, each Claimant will recover pro rata. The term “renter” shall mean anyone who pays rent.

2. If you answered yes to Question No. 1, please check the appropriate Response boxes about the type of property damage suffered.

Click **only** the below boxes that apply to you:

- ☐ I had or have a duty to clean the cistern of an impacted structure with a cistern in the Affected Geographic Area. Please identify the address of the cistern:

Address/Plot No. & Estate:

[illegible]

City/Town:

[illegible]

State:

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ZIP Code:

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- ☐ I owned or own or rented or rent an impacted structure in the Affected Geographic Area and resided or reside in the structure on or after February 3, 2021. Please identify the address of the structure:

Address/Plot No. & Estate:

[illegible]

City/Town:

[illegible]

State:

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ZIP Code:

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- ☐ I owned or own or rented or rent an impacted structure in the Affected Geographic Area but did **not** reside in the structure on or after February 3, 2021. Please identify the address of the structure:

Address/Plot No. & Estate:

[illegible]

City/Town:

[illegible]

State:

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ZIP Code:

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Had or have a duty to clean the cistern:

☐ Yes ☐ No

Owned or own or rented or rent the impacted structure in the Affected Geographic Area and resided or reside in the structure on or after February 3, 2021:

☐ Yes ☐ No

Owned or own or rented or rent
the impacted structure in the
Affected Geographic Area but
did not reside in the structure on
or after February 3, 2021:

☐ Yes ☐ No

4. If, in response to Question No. 2, you indicated that you own or owned or rented or rent an impacted structure in the Affected Geographic Area, but other people also own or rent the same property*, please indicate the percentage of your ownership or rental payments.

*If you (or you and your spouse) own the entire property or pay the entire rent, you do not need to fill in Question No. 4.

			•			%
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5. How long, if at all, did you reside, or have you resided, in an impacted structure with a cistern in the Affected Geographic Area and use or used cistern water at that residence?

Check **only one** of the boxes that apply below, as appropriate:

- ☐ I did not reside in an impacted structure with a cistern in the Affected Geographic Area **or** did not use cistern water at that residence.
- ☐ I have resided in an impacted structure with a cistern in the Affected Geographic Area **for less than one month** during the time period from February 3, 2021 to present **and** use or used cistern water at that residence.
- ☐ I have resided in an impacted structure with a cistern in the Affected Geographic Area **for more than one month** during the time period from February 3, 2021 to present **and** use or used cistern water at that residence.

6. If, in response to Question No. 5, you selected a box indicating that you used **cistern water** from an impacted structure with a cistern in the Affected Geographic Area, did **other people** (counting only your spouse and any minor children but not you) also use that cistern water.

Check the appropriate box:

☐ Yes ☐ No

7. If, in response to Question No. 6, you selected a box indicating that other people used **cistern water** from an impacted structure with a cistern in the Affected Geographic Area, please indicate below the number of **other people*** (counting only your spouse and any minor children but not you) who also used that cistern water and **provide each of their names**.

*Note, please do not include adult children or adult residents as other adults (other than a spouse) must submit a separate Claim Form.

Number of other people:

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First Name

[illegible]

MI

7

Last Name

[illegible]

First Name

[illegible]

MI

7

Last Name

[illegible]

First Name

[illegible]

MI

7

Last Name

[illegible]



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8. Were you **present** in the Affected Geographic Area during any of the Incidents of February 4, 2021, April 23, 2021, May 5, 2021, and May 12, 2021 ("the Incidents")?

Check the appropriate box:

☐ Yes ☐ No

9. Were any of your minor children and/or spouse **present** in the Affected Geographic Area **during any of the Incidents**?

Check the appropriate box:

☐ Yes ☐ No

10. Counting only your spouse and/or minor children, please indicate below the number of other people who were **present** in the Affected Geographic Area during any of the Incidents and **provide each of their names**.*

*Note, please do not include adult children as they must submit a separate Claim Form.

Number of other people:

First Name

MI

Last Name

First Name

MI

Last Name

First Name

MI

Last Name

11. Were you **present on a regular basis** (for example working or residing) in the Affected Geographic Area for more than one month during the time-period from February 3, 2021 to May 26, 2021?

Check the appropriate box:

☐ Yes ☐ No

12. Were any of your minor children and/or spouse **present on a regular basis** (for example working or residing) in the Affected Geographic Area for more than one month during the time-period from February 3, 2021 to May 26, 2021?

Check the appropriate box:

☐ Yes ☐ No

13. Counting only your spouse and/or minor children, please indicate below the number of other people who were **present on a regular basis** (for example working or residing) in the Affected Geographic Area for more than one month during the time-period from February 3, 2021 to May 26, 2021 and **provide each of their names**.*

*Note, please do not include adult children as they must submit a separate Claim Form.

Number of other people:

First Name

MI

Last Name

First Name

MI

Last Name

First Name

MI

Last Name

[illegible]

1

[illegible][illegible]

9

[illegible][illegible]

1

[illegible][illegible]

9

[illegible]

-
-
-
-
-

-
-
-

- ☐ Yes ☐ No



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17. Describe any **lost wages**, including the amount, that you suffered because of the release Incidents from the Limetree Bay Refinery (**leave blank if inapplicable**)*.

Specific description of any lost wages for which you are requesting reimbursement	Date of the expense	Dollar amount of the specific expense
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>
Total Amount Claimed:		<div>\$</div> <div></div> <div></div> <div></div> <div></div> <div></div> <div>.</div> <div></div> <div></div>

*To recover for such lost wages, you must provide supporting documentation such as tax forms or similar financial documents showing business income losses incurred, including decreased earnings or revenue figures for the period after the Incidents as compared to before.

18. Describe any **business losses**, including the amount, that you suffered because of the release Incidents from the Limetree Bay Refinery (leave blank if inapplicable).*

Specific description of any business losses for which you are requesting reimbursement	Date of the expense	Dollar amount of the specific expense
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
	MM - DD - YYYY	\$.
Total Amount Claimed:		\$.

*To recover for such losses, you must provide supporting documentation such as tax forms or similar financial documents showing business income losses incurred, including decreased earnings or revenue figures for the period after the Incidents as compared to before.



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19. Set forth and describe any **out-of-pocket expenses** that you incurred because of the release Incidents from the Limetree Bay Refinery, such as for the purchase of water, travel related to obtaining water, cistern cleaning, unreimbursed medical expenses, or any other unreimbursed expenses arising from the Incidents, and the specific amount of each such expenses incurred (**leave blank if inapplicable**)*.

Specific description of each non-reimbursed out-of-pocket expense for which you are requesting reimbursement	Date of the expense	Dollar amount of the specific expense
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
	<div>MM</div> <div>DD</div> <div>YYYY</div>	\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>
Total Amount Claimed:		\$ <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> . <div></div> <div></div>

*To recover for any such losses, you must attach and return to the Settlement Administrator the corresponding receipt, invoice, credit card statement, medical record, insurance record, copy of returned check, or other reasonable form of evidence documenting that you incurred each expense listed above.

Please make sure the email or phone number you provide to receive payments matches your contact information above. Please check one of the following payment options for your claimed Settlement Payment:

PAYMENT ELECTION

Please fill out **ONLY ONE** of the payment options below.

#1 Digital Payment Account – Payment Option

☐ Venmo ☐ Zelle

*Provide the email **OR** phone number, **NOT** both, associated with your selected digital payment account.*

Email Address

[illegible]

OR Phone Number **Zelle** does not work with 340 area code phone numbers; please use email for Zelle.

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#2 ACH Transfer: Direct Electronic Payment to a Bank Account – Payment Option

☐ Checking Account ☐ Savings Account

Routing Number

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Account Number

[illegible]

#3 Physical Check to be Sent by Mail – Payment Option

Sent by mail to the address on this Claim.

Physical Check

If you select more than one payment option, you will be mailed a check.

PART IV – CERTIFICATION AND DECLARATION

I hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 and the laws of the United States of America that all of the information I have provided above is true and correct to the best of my knowledge, and that I (a) owned **or** rented property (real and/or personal) in the Affected Geographic Area on or after February 3, 2021; **or** (b) resided in, worked in, owned or operated a business in, or was present in the Affected Geographic Area during the time period from February 3, 2021 to May 26, 2021.

Signature

Date:

$$\begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|} \hline & \\ \hline \end{array} - \begin{array}{|c|c|c|c|} \hline & & & \\ \hline \end{array}$$

MM DD YYYY

MM

DD

YYYY

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Print Name

PART V – REMINDER CHECKLIST BEFORE YOU SUBMIT THIS CLAIM FORM

1. Make sure that you fully completed Part I – Claimant Information.
2. Make sure that you fully completed Part II as applicable to your personal situation.
3. Make sure that you fully completed Part III – Form of Payment.
4. Make sure that you signed the Certification and Declaration in Part IV.
5. Make sure that when you return your Claim Form you include a copy of all required documentation requested above.
6. Make sure that you retain a copy of this Claim Form and your supporting documentation for your records.



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LIMETREE BAY SETTLEMENT LIEN DISCLOSURE FORM

A. CLAIMANT INFORMATION

Claimant Name:	Last	First	Middle	Suffix
Claimant ID:				
Claimant Date of Birth:		Claimant Social Security Number:		
Reason for No Social Security Number (if applicable):	☐ Foreign citizen ☐ Individual Taxpayer Identification Number (ITIN) only ☐ Other			
Claimant Gender:	☐ Male ☐ Female			

B. THE PURPOSE OF THIS FORM

This form needs to be filled out if you responded to Question No. 15 on the Claim Form that you had physical or emotional health manifestations that resulted from exposure to the release Incidents from the Limetree Bay Refinery for which you did seek medical treatment. **If you did not see a medical professional as a result of the Incidents, please respond to Question No. 14 instead, and you do not need to fill out this Form.**

The purpose of this Lien Disclosure Form ("Form") is to **gather information for healthcare insurers who paid for medical care related to your settlement arising from the Limetree Bay litigation ("Settlement")**. This disclosure will authorize the **Healthcare Compliance Administrator ("HCA"), Wolf Global Compliance LLC**, to address certain Medical Liens as part of any potential personal injury settlement. A Medical Lien is the reimbursement amount that your healthcare insurer(s) may pursue from any settlement, judgment, or award for the amount the insurer paid for related medical care.

Using information provided on this Form (first and last name, date of birth, Social Security Number, and gender), the **HCA will affirmatively identify and resolve**, either through global lien resolution or expenditure-based lien resolution, **any Medical Liens you may have from Medicare Part A and Part B ("Traditional Medicare")**.

Additionally, the HCA will identify and resolve Medical Liens you may have from any other health insurer to the extent you provide the requested information in Section D of this form.

It is important that neither you nor your attorney individually contact, report to, or respond to correspondence from any Insurer identified in this Form concerning potential Medical Liens related to your Settlement. The HCA will handle and resolve such correspondence.

Medical Liens asserted by healthcare insurers that you do not identify in this form will be your sole responsibility - the HCA will not assist with them, and no funds will be held back from your Settlement to address them.



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C. MEDICARE (PART A AND PART B)

In accordance with Section B of this Form, the HCA will automatically identify and resolve, either through global lien resolution or expenditure-based lien resolution, any Medical Lien you may have from Part A and Part B (“Traditional Medicare”). **No action is required on your part.**

D. OTHER PRIVATE AND GOVERNMENT INSURERS

In accordance with Section B of this Form, the HCA will identify and resolve any Medical Liens you may have from any other health insurer **only if you indicate “Yes” and provide complete information below.**

If you do not respond, indicate “No,” or provide incomplete information, the HCA will not take action on your behalf with respect to potential Medical Liens from the health insurer, and it will be solely your responsibility to resolve any such potential Medical Lien obligation that may arise in the future.

Did any health insurer pay for medical care that you sought as a result of the exposure to the release Incidents from the Limetree Bay Refinery that is the subject of your Settlement?

☐ Yes

☐ No

If you answered “Yes” above, provide the name of the health insurer, group, and plan (as shown on your insurance card) that paid for medical care that you sought as a result of the exposure to the release Incidents from the Limetree Bay Refinery that is the subject of your Settlement:

Additional space if you are providing information for more than one health insurer, group, or plan:

E. AUTHORIZATION FOR USE AND DISCLOSURE OF YOUR INFORMATION

This Form authorizes the disclosure of “Protected Health Information” as that term is defined in 45 C.F.R. § 160.103. Protected Health Information includes, but is not limited to, information regarding the Claimant’s medical care, treatment, and medical expenses.

By signing and submitting this Form, I authorize the use and disclosure of all Protected Health Information regarding my (or the Claimant’s, if signed by a Representative) medical care, treatment, physical or mental condition, and medical expenses relating to my claim to: (1) Wolf Global Compliance, LLC (229 S. Brevard Street, Ste. 300, Charlotte, North Carolina 28202) and its agents for allocation of any settlement or judgment payment and use and/or disclosure to the holders of any liens, claims, or rights of subrogation, indemnity, reimbursement, conditional or other payments, or interests of any type, including Medicare or any other insurer that I identified in this Form (collectively, “Lienholders”) for the purpose of identifying and resolving potential liens in connection with any award that I may receive; (2) the Lienholders for disclosure to Wolf Global Compliance, LLC for the purpose of identifying and resolving any potential liens in connection with any award that I may receive. These records will be used or disclosed solely in connection with any lien resolution involving the Claimant named in Section A.

By signing below, I acknowledge and understand all of the following and authorize Wolf Global Compliance, LLC as the HCA, to act on my behalf with each of the agencies or groups disclosed in this Form that provided healthcare coverage to me for medical care that I sought as a result of the exposure to the release Incidents from the Limetree Bay Refinery that is the subject of my Settlement:

1. I have the right to revoke this authorization at any time. If I wish to revoke the authorization, I must do so in writing and must provide my written revocation to my lawyer. The written revocation must be signed and dated. The revocation will not apply to any disclosures that already have been made in reliance on this authorization prior to the date upon which my written revocation is received.



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2. My authorization of the disclosure of the subject Claimant's Protected Health Information is voluntary, which means I can refuse to sign this Form. I do not need to sign this Form to obtain health treatment from any medical provider or to enroll in or be eligible for any health plan benefits. However, I recognize that if I do not sign this Form, Wolf Global Compliance, LLC may not resolve Medical Liens on my behalf.
3. Any Protected Health Information or other information submitted to Wolf Global Compliance, LLC may be disclosed to potential Lienholders and may be subject to re-disclosure by such person/entity and may no longer be protected by applicable federal and state privacy laws. Each of those persons and entities, however, is permitted to use and disclose my information only in accordance with this Form, any contract executed pursuant to any Settlement Agreement, orders of the Court, and/or applicable law.
4. My Protected Health Information may include information relating to sexually transmitted disease ("STD"), acquired immunodeficiency syndrome ("AIDS"), or human immunodeficiency virus ("HIV"); behavioral or mental health services; treatment for alcohol and drug abuse; and treatment for sexual/physical/mental abuse.
5. Wolf Global Compliance, LLC may represent me and act on my behalf with respect to any potential recovery claim that Medicare may have.
6. I will cooperate fully with Wolf Global Compliance, LLC and their efforts to resolve Medical Liens on my behalf, including providing and/or signing any additional authorization documents required by Lienholders.
7. I specifically authorize any State Medicaid agencies identified in Section D to exchange my Protected Health Information with Wolf Global Compliance, LLC.
8. This Form is valid until three years from the date of my signature in Section F.
9. I have a right to receive and retain a copy of this Form.
10. Any photostatic copy of this Form will have the same authority as the original and may be substituted in its place.
11. I release Wolf Global Compliance, LLC from all liability arising from their efforts to resolve Medical Liens on my behalf.

F. SIGNATURE

As the Claimant, or the legal Representative of the Deceased Claimant identified in Section A of this Form, I provide the above information so that my attorneys and/or the HCA can identify and resolve any Medical Liens asserted by any Healthcare Insurers as defined above. I understand that all Medical Liens not being resolved by the HCA, including those asserted by insurers that I did not identify in this form, are my sole responsibility.

I declare under penalty of perjury that the information provided in this Form is true and accurate.

Claimant or Representative Signature (Signatures must be handwritten ("wet ink") or electronically signed through an acceptable electronic format.)			_____ DATE	
Printed Name of Person Signing	Last	First	Middle	Suffix

G. HOW TO SUBMIT THIS FORM

Send the completed and signed version of this Form with Your Claim Form.