Form **5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

# Annual Return/Report of Employee Benefit Plan

**This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).**

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089

**2008**

**This Form is Open to Public Inspection.**

## Part I Annual Report Identification Information

**For the calendar plan year 2008 or fiscal plan year beginning** , **and ending** ,

**A** This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan; or
(2) ☒ a single-employer plan (other than a multiple-employer plan); (4) ☐ a DFE (specify) _____

**B** This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
(2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

**C** If the plan is a collectively-bargained plan, check here . . . . . ▶ ☒

**D** If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) . . . . . ▶ ☒

## Part II Basic Plan Information -- enter all requested information.

**1a** Name of plan
MARATHON OIL COMPANY WELLNESS PLAN

**1b** Three-digit plan number (PN) ▶ 506

**1c** Effective date of plan (mo., day, yr.) 04/01/1990

**2a** Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
MARATHON OIL COMPANY

539 SOUTH MAIN STREET

FINDLAY OH 45840-3295

**2b** Employer Identification Number (EIN) 25-1410539

**2c** Sponsor's telephone number 419-422-2121

**2d** Business code (see instructions) 324110

**Caution:** A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

**SIGN HERE** _____ 10-08-09 B. J. LINDER, M.D.
Signature of plan administrator | Date | Type or print name of individual signing as plan administrator

**SIGN HERE** _____
Signature of employer/plan sponsor/DFE | Date | Type or print name of individual signing as employer, plan sponsor or DFE

**For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.** v11.3 Form **5500** (2008)

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**3a** Plan administrator's name and address (If same as plan sponsor, enter "Same")
B. J. LINDER

539 SOUTH MAIN STREET

FINDLAY OH 45840-3295

**3b** Administrator's EIN
32-0035204

**3c** Administrator's telephone number
419-422-2121

**4** If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
**a** Sponsor's name

**b** EIN

**c** PN

**5** Preparer information (optional) **a** Name (including firm name, if applicable) and address

**b** EIN

**c** Telephone number

| | | |
|---|---|---|
| **6** Total number of participants at the beginning of the plan year | **6** | 9212 |
| **7** Number of participants as of the end of the plan year (welfare plans complete only lines **7a, 7b, 7c,** and **7d**) | | |
| **a** Active participants | **7a** | 9682 |
| **b** Retired or separated participants receiving benefits | **7b** | 0 |
| **c** Other retired or separated participants entitled to future benefits | **7c** | 0 |
| **d** Subtotal. Add lines **7a, 7b,** and **7c** | **7d** | 9682 |
| **e** Deceased participants whose beneficiaries are receiving or are entitled to receive benefits | **7e** | |
| **f** Total. Add lines **7d** and **7e** | **7f** | |
| **g** Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) | **7g** | |
| **h** Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested | **7h** | |
| **i** If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500) | **7i** | |

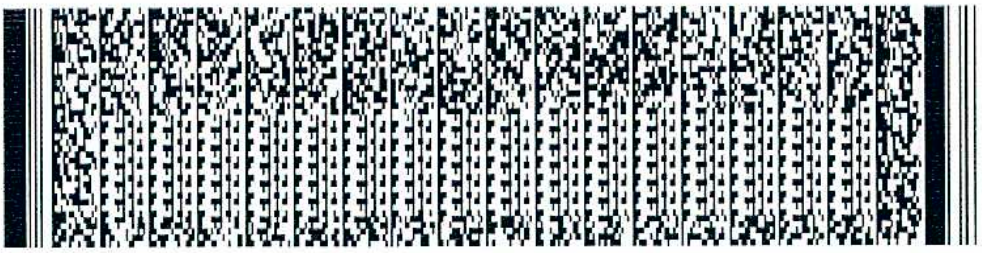
**8** Benefits provided under the plan (complete **8a** and **8b**, as applicable)

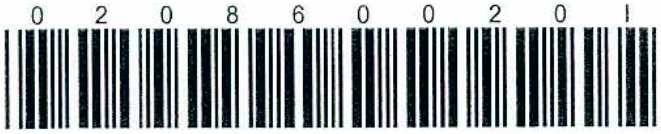
**a** [ ] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**b** [X] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions): [4A] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

**9a** Plan funding arrangement (check all that apply)
- (1) [ ] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [X] General assets of the sponsor

**9b** Plan benefit arrangement (check all that apply)
- (1) [ ] Insurance
- (2) [ ] Code section 412(e)(3) insurance contracts
- (3) [ ] Trust
- (4) [X] General assets of the sponsor





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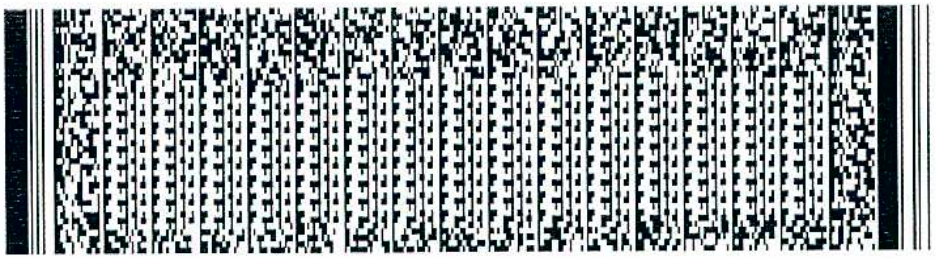
**10** Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

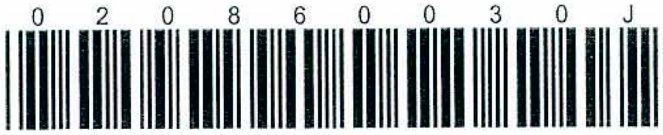
**a Pension Benefit Schedules**

- (1) ☐ R (Retirement Plan Information)
- (2) ☐ B (Actuarial Information)
- (3) ☐ E (ESOP Annual Information)
- (4) ☐ SSA (Separated Vested Participant Information)

**b Financial Schedules**

- (1) ☐ H (Financial Information)
- (2) ☐ I (Financial Information -- Small Plan)
- (3) ☐ A (Insurance Information)
- (4) ☐ C (Service Provider Information)
- (5) ☐ D (DFE/Participating Plan Information)
- (6) ☐ G (Financial Transaction Schedules)





Form **5558**
(Rev. January 2008)
Department of the Treasury
Internal Revenue Service

# Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions on page 3.

OMB No. 1545-0212

File With IRS Only

## Part I Identification

A Name of filer, plan administrator, or plan sponsor (see instructions)
Marathon Oil Company
Number, street, and room or suite no. (If a P.O. box, see instructions)
539 South Main Street
City or town, state, and ZIP code
Findlay, OH 45840

B Filer's identifying number (see instructions).
[X] Employer identification number (EIN).
25 : 1410539
[ ] Social security number (SSN)

| C Plan name | Plan number | Plan year ending— MM | DD | YYYY |
|---|---|---|---|---|
| 1 See Attached | | | | |
| 2 | | | | |
| 3 | | | | |

## Part II Extension of Time to File Form 5500 or Form 5500-EZ *(see instructions)*

1 I request an extension of time until 10 / 15 / 2009 to file Form 5500 or Form 5500-EZ.

The application **is automatically approved** to the date shown on line 1 (above) if: **(a)** the Form 5558 is filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and **(b)** the date on line 1 is no more than 2½ months after the normal due date.

**You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed in C above.**

**Note.** A signature is not required if you are requesting an extension to file Form 5500 or Form 5500-EZ.

## Part III Extension of Time to File Form 5330 *(see instructions)*

2 I request an extension of time until ___ / ___ / ___ to file Form 5330.
You may be approved for up to a six (6) month extension to file Form 5330, after the normal due date of Form 5330.

a Enter the Code section(s) imposing the tax . . . . . ► a

b Enter the payment amount attached . . . . . ► b

c For excise taxes under section 4980 or 4980F of the Code, enter the reversion/amendment date . . . ► c

3 State in detail why you need the extension

Under penalties of perjury, I declare that to the best of my knowledge and belief, the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ► Date ►

MARATHON OIL COMPANY
539 South Main Street
Findlay, OH 45840
Sponsor EIN: 25-1410539

| PLAN NAME | TYPE of PLAN | Plan # | PLAN YEAR ENDING |
|---|---|---|---|
| Retirement Plan of Marathon Oil Company | Pension | 001 | 12/31/2008 |
| Marathon Oil Company Thrift Plan | Pension | 003 | 12/31/2008 |
| Accidental Death & Dismemberment Plan of Marathon Oil Company | Welfare | 501 | 12/31/2008 |
| Life Insurance Plan of Marathon Oil Company | Welfare | 502 | 12/31/2008 |
| Long Term Disability Plan of Marathon Oil Company | Welfare | 503 | 12/31/2008 |
| Health Plan of Marathon Oil Company | Welfare | 504 | 12/31/2008 |
| Marathon Oil Company Wellness Plan | Welfare | 506 | 12/31/2008 |
| Marathon Oil Company Employee Assistance Program | Welfare | 507 | 12/31/2008 |
| Dental Assistance Plan of Marathon Oil Company | Welfare | 509 | 12/31/2008 |
| Termination Allowance Plan of Marathon Oil Company | Welfare | 521 | 12/31/2008 |
| Occupational Accidental Death Benefit Plan of Marathon Oil Company | Welfare | 522 | 12/31/2008 |
| Cigna Dental Health, Managed Dental Care Program of Marathon Oil Company | Welfare | 523 | 12/31/2008 |
| Life Insurance Plan | Welfare | 524 | 12/31/2008 |
| Change in Control Severance Benefits Plan of Marathon Oil Company | Welfare | 528 | 12/31/2008 |
| CIGNA international Health Plan | Welfare | 529 | 12/31/2008 |
| Vision Assistance Plan of Marathon Oil Company | Welfare | 530 | 12/31/2008 |