Please return by:

MARATHON OIL COMPANY
65 AND OVER RETIREE/SPOUSE/SURVIVING SPOUSE
ENROLLMENT FORM

PERSONNEL NO. ____________________ **SOCIAL SECURITY NO. OF MEMBER** ____________________

MEMBER'S NAME ____________________ ____________________
First Initial Last Date of Birth

NAME OF PERSON TURNING 65 ____________________ ____________________ ____________________
Social Security No. Date of Birth

EFFECTIVE DATE ____________________
First day of month in which retiree, spouse or survivor turns age 65

ENROLL IN THE MARATHON OIL COMPANY POST-65 HEALTH BENEFITS – for members enrolled in Federal Medicare insurance:

☐ Retiree ☐ Spouse ☐ Surviving Spouse*

OR

WAIVE PARTICIPATION

☐ Retiree ☐ Spouse ☐ Surviving Spouse*
☐ Retiree waives participation due to enrollment in Medicare C, Tri-Care, or use of Veterans' Administration.

* A Surviving Spouse who remarries is no longer eligible for coverage under the Marathon Oil Company Plans and must notify the company immediately.

If I decide to waive coverage, I will notify the Company by contacting Marathon Oil Benefits through email, fax, or the 1-855-652-3067 number.

I understand that the medical benefits currently offered under the above-listed options never vest, either before or after my retirement, are not considered as part of my earned compensation, and may be changed or eliminated in the future by the Company.

____________________ ____________________
Member Signature Date

ADDRESS ____________________ ____________________
Street City State County Zip Code Phone

Please list all family members who are covered by either the Company Health Plan (under 65) or Med Supp. Social Security number and date of birth are required.

Name	Relationship	Social Security No.	Birth Date

RETURN COMPLETED FORM TO THE MARATHON OIL BENEFITS DEPARTMENT, HEALTH & WELFARE BENEFITS, 5555 SAN FELIPE STREET, HOUSTON, TX 77056 OR FAX TO 713-513-4495 OR SCAN AND EMAIL TO MROBenefitsHelp@MarathonOil.com