MARATHON OIL COMPANY
BENEFIT CHANGE FORM
FOR EMPLOYEES

Date Received by Company _____
Employee Number of Company Rep. _____
Name of Company Rep. _____

Employee Name _____ Employee Number _____

Daytime Phone Number ( ) _____

If your spouse or domestic partner is a Marathon Oil Company employee or retiree, provide their Name and Employee Number below.

Name _____ Employee Number _____

Benefit Changes can only be made in accordance with Plan rules and IRS regulations. Submit changes to the Benefits Department within 31 days of a qualifying event. Examples of a Qualifying Event: Marriage, Birth, Adoption, Divorce, Death, Dependent No Longer Eligible, Loss of Other Employer Coverage

Refer to the "Affirmation for Eligible Dependents" portion of this form (Section 3) for the definition of children who are eligible for coverage in the plans.

DENTAL PLAN

☐ WAIVE ☐ ENROLL ☐ CHANGE ☐ NO CHANGE

EVENT

Change in Family/Employment Status. . . . . .Qualifying Event _____ Event Date _____

COVERAGE CATEGORY

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family
☐ Employee & Domestic Partner[1] ☐ Employee & Domestic Partner[1] & Children ☐ Employee & Children of Domestic Partner[1]

HEALTH PLAN

☐ WAIVE ☐ ENROLL ☐ CHANGE ☐ NO CHANGE

EVENTS

☐ Change in Location (Out of Area or CIGNA Global only). . .Date of Address Change _____
☐ Change in Family/Employment Status . . . . . .Qualifying Event _____ Event Date _____

COVERAGE CATEGORY

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family
☐ Employee & Domestic Partner[1] ☐ Employee & Domestic Partner[1] & Children ☐ Employee & Children of Domestic Partner[1]

OPTION (Select one)

☐ **Health Investment Plan Value Option** - UnitedHealthcare
☐ **Health Investment Plan Option Plus Option**- UnitedHealthcare
☐ **CIGNA Global Health and Dental** (Available to "Designated International" employees)

FOR ANY EMPLOYEE AND/OR DEPENDENT ELIGIBLE FOR MEDICARE DUE TO DISABILITY (and for whom Medicare is Primary)

☐ Medicare Supplement for: ☐ Employee ☐ Spouse ☐ Domestic Partner[1]

NOTE: Attach photocopy of both sides of the Medicare ID card. If Medicare is in combination with other Marathon Oil Company Health Plan coverage, explain below:

_____

_____

_____

[1] Completion of the Marathon Oil Company Affidavit of Domestic Partner Relationship is required for benefit enrollment of a domestic partner. The form can be found at www.MRObenefits.com.

EMPLOYEE NAME_____ EMPLOYEE NO. _____

VISION PLAN

☐ WAIVE ☐ ENROLL ☐ CHANGE ☐ NO CHANGE

EVENTS

☐ Change in Family/Employment Status . . . . . Qualifying Event _____ Event Date _____

COVERAGE CATEGORY
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family
☐ Employee & Domestic Partner [1] ☐ Employee & Domestic Partner[1] & Children ☐ Employee & Children of Domestic Partner[1]

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PLAN (AD&D)

☐ WAIVE ☐ ENROLL ☐ CHANGE ☐ NO CHANGE

EVENT

Change in Family/Employment Status . . . . . Qualifying Event _____ Event Date _____

COVERAGE CATEGORY
☐ Employee Only ☐ Employee & Spouse [2] ☐ Employee & Child(ren) [2] ☐ Employee & Family [2]

AMOUNT OF COVERAGE $_____,000 (Increments of $10,000 up to $100,000; or $150,000, $200,000 or $250,000)

CONTRIBUTORY LIFE INSURANCE PLAN (For coverage in addition to Company-paid life insurance of two times pay.)

☐ WAIVE
- ☐ Employee (All dependent life insurance will be terminated)
- ☐ Spouse[2]
- ☐ Children[2]

☐ ENROLL
- ☐ Employee (Initial enrollment is 1X pay)
- ☐ Spouse[2] (Eligible if employee is enrolled in Optional Contributory Life Insurance)
- ☐ Children[2] (Eligible if employee is enrolled in Optional Contributory Life Insurance

☐ CHANGE (See "EVENTS" below)

☐ NO CHANGE

EVENTS

1. Employees may increase one times covered compensation per year (up to 6X pay).
2. Spouse coverage may increase one $10,000 increment each year (up to $100,000 max).
3. Coverage may decrease any number of levels each year.

☐ Change in Family Status (Additional rules may apply)

☐ Marriage (Initial enrollment can be from $10,000 to $50,000) . . . . . Date _____

☐ Birth/Adoption (You may enroll but may not change the coverage amount if other children are previously covered). . . . . Date _____

COVERAGE LEVELS

Employee	☐ 1X pay	☐ 2X pay	☐ 3X pay	☐ 4X pay	☐ 5X pay	☐ 6X pay				
Children (Each)	☐ $10,000	☐ $20,000	☐ $30,000							
Spouse	☐ $10,000	☐ $20,000	☐ $30,000	☐ $40,000	☐ $50,000 Maximum Initial Enrollment	☐ $60,000 (if previous coverage was $50,000)	☐ $70,000 (if previous coverage was $60,000)	☐ $80,000 (if previous coverage was $70,000)	☐ $90,000 (if previous coverage was $80,000)	☐ $100,000 (if previous coverage was $90,000)

LONG-TERM DISABILITY PLAN

☐ Late Enrollment. . . . . (if you are not already enrolled)

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[1] Completion of the Marathon Oil Company Affidavit of Domestic Partner Relationship is required for benefit enrollment of a non-spouse domestic partner. The form can be found at www.MRObenefits.com.

[2] Changes to Spouse and/or Dependent AD&D and Life Insurance will be effective the later of the date of the event or the date the form is received by the Company.

EMPLOYEE NAME ______________________ EMPLOYEE NO. ______________

FLEXIBLE SPENDING ACCOUNTS

Dependent Care Spending Account: ☐ Enroll $__________ Annual Amount

Qualifying Event ______________________ Date of Event ______________

Limited Health Care Spending Account: (HIP Members only) ☐ Enroll $__________ Annual Amount

Qualifying Event ______________________ Date of Event ______________

Health Savings Account (HSA): (HIP Members only) ☐ Enroll $__________ Annual Amount

Qualifying Event ______________________ Date of Event ______________

DEPENDENT PARTICIPATION[3]

DENTAL Add	DENTAL Drop	HEALTH Add	HEALTH Drop	VISION Add	VISION Drop	AD&D[2] Add	AD&D[2] Drop	LIFE INS.[2] Add	LIFE INS.[2] Drop	Name	Relationship	Event*	Event Date
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐				
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐				
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐				
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☐	☐	☐	☐	☐	☐	☐	☐	☐	☐				

*Event Examples: Marriage, Birth, Adoption, Divorce, Death, Dependent No Longer Eligible, Loss of Other Employer Coverage.

I hereby certify that I have been furnished copies of the above plans and I agree to the terms of each plan to which I subscribe and to execute such forms as may be required by the Plan Administrator(s) or by the rules and regulations governing such plan. I direct that any premiums required of me be deducted from my gross pay according to the applicable payroll procedures.

______________________ Employee Signature

______________ Date

AFFIRMATION FOR ELIGIBLE DEPENDENT(S) ON PAGE 4.

[1] Completion of the Marathon Oil Company Affidavit of Domestic Partner Relationship is required for benefit enrollment of a non-spouse domestic partner. The form can be found at www.MRObenefits.com.

[2] Adding or changing Spouse and/or Dependent AD&D and Life Insurance will be effective the later of the date of the event or the date the form is received by the Company.

[3] If you have dependents, you MUST complete the Affirmation for Eligible Dependants.

EMPLOYEE NAME_____ EMPLOYEE NO. _____

AFFIRMATION FOR ELIGIBLE DEPENDENT(S)

This form is to verify to the Plan Administrator of the Marathon Oil Company benefit plans that the person(s) listed below meet the qualifications for coverage as dependents under the respective Plans. Please read the definitions carefully as provided in the applicable Plan on www.MRObenefits.com before signing this form. By signing, you are attesting that the qualifications are met for every individual listed. The Plan Administrator reserves the right to request documentation for this affirmation at any time.

SECTION 1 – REASON FOR ADDING DEPENDENT(S)

Event Date: _____

____Birth ____Court Order ____Loss of Other Employer Coverage

____Adoption ____Marriage

SECTION 2 – SPOUSE INFORMATION

I certify that the person listed below is my legal spouse:

Last Name	First Name	MI	Birth Date	Social Security No.	Gender (M/F)
			- -	- -	

If your spouse is a Marathon Oil Company employee or retiree, provide their Employee No. _____

To add a non-spouse Domestic Partner and eligible children of a Domestic Partner, you must complete the MOC Affidavit of Domestic Partner Relationship form, which can be printed from www.MRObenefits.com.

SECTION 3 – CHILD INFORMATION

A child dependent must be under the age of 26. An unmarried disabled child age 26 or older may be eligible; however, an additional form obtained from the Benefits Department must be completed and returned. In addition, the child must be one of the following:

Relationship Codes:

1. A natural child or legally adopted child. **Attach a copy of adoption papers, if applicable.**
2. A stepchild.
3. A child whose natural parents are deceased, who permanently resides with you, and for whom you have legal custody as determined by a court of competent jurisdiction. **Attach a copy of supporting court document(s).**

I certify that the person(s) below meet the eligibility requirements for dependent coverage:

- In the Relationship column, please indicate the Relationship Type as **1,** 2 or **3** based on the definitions above. **If you indicate a Relationship Type 1 (adoption) or 3, you must provide the appropriate court document(s) along with this signed form before dependent coverage can be provided.**
- Additional copies of this form should be used if there are more than four eligible children.

Last Name	First Name	MI	Birth Date	Social Security No.[A]	Gender (M/F)	Relationship (1, 2 or 3)	"X" if Disabled Age 26+
			- -	- -			
			- -	- -			
			- -	- -			
			- -	- -			

[A] If SSN for a newborn is not available, call or email Ask HR when the number is received.

I certify that the information given above is true and correct to the best of my knowledge. I understand that any false statements could result in termination of coverage for me and any dependents. I acknowledge it is my responsibility to notify the Company within 31 days of the date a covered family member no longer qualifies as an eligible dependent.

Signature_____ Date _____

RETURN COMPLETED FORM TO MARATHON OIL COMPANY, ATTN: Ask HR, 5555 SAN FELIPE STREET, HOUSTON, TX 77056, FAX TO 713-513-4495, OR SCAN AND EMAIL TO: AskHR@marathonoil.com.
QUESTIONS CALL 1-855-652-3067