2018 Marathon Oil Company Benefit Enrollment Form for Employees

READ THIS INFORMATION FIRST:

- **This form is to be completed by Regular Full or Part-time New Hires, Rehires, or employees changing from Casual to Regular employment status.**
- **BENEFIT COVERAGE WILL BE EFFECTIVE ON YOUR DATE OF HIRE.**
- **Benefits enrollment must be completed within 30 days of hire or the Company will deem that you have waived all benefits and you will have no benefits coverage.**
- **Complete and submit this form in its entirety.**
- **You can submit the document(s) to Ask HR in one of the following ways:**
  - **Scan and email to: AskHR@MarathonOil.com or**
  - **Fax to: 713-513-4495 or**
  - **Mail to: Marathon Oil Company, Ask HR, 5555 San Felipe Street, Houston, TX 77056**

PLEASE NOTE:

- **The costs of Health and Dental Plan coverages listed on this form are for Regular Full-time employees. The costs for Regular Part-Time employees can be found at www.MRObenefits.com**

Part I: About You

Name: _____ (First, MI, Last)

Employee Number: _____

Date of Birth: _____

Date of Hire or Employment Type Change: _____

Daytime Phone Number: _____

Social Security Number: _____

Part II: Benefit Elections

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

DENTAL PLAN

☐ I do not want Dental coverage

If you want coverage, check a Coverage Category below. The monthly cost for coverage is listed below.

Coverage Category (select one)

☐ Employee Only	☐ Employee & Spouse[1]	☐ Employee & Child(ren)[1]	☐ Employee & Family[1]
	☐ Employee & Domestic Partner[2]	☐ Employee & Child of Domestic Partner[2]	☐ Employee & Domestic Partner & Child(ren)[1, 2]
$8	$16	$17	$27

EMPLOYEE ASSISTANCE PROGRAM (EAP)

You are automatically enrolled in this Plan at no cost to you. The EAP is a program designed to offer a professional, confidential source of help for employees and their covered dependents, who may want to seek assistance with personal problems. Optum EAP counselors are available to help 24-hours per day, seven days per week.

HEALTH PLAN

☐ I do not want Health coverage

If you want coverage, check an Option and a Coverage Category below. The monthly cost for coverage is listed below.

Coverage Category (select one)

Options (select one)	☐ Employee Only	☐ Employee & Spouse[1]	☐ Employee & Child(ren)[1]	☐ Employee & Family[1]
		☐ Employee & Domestic Partner[2]	☐ Employee & Child of Domestic Partner[2]	☐ Employee & Domestic Partner & Child(ren)[1, 2]
☐ **Health Investment Plan Value**	$124	$274	$249	$373
☐ **Health Investment Plan Plus**	$94	$209	$190	$284
☐ **CIGNA Global** Health and Dental Available to "Designated International" Employees only	$112	$224	$203	$339

[1] Also complete "Part V: Dependent Information" on this form.

[2] Completion of the MOC 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.

VISION PLAN

☐ I do not want Vision coverage

If you want coverage, check a Coverage Category below. The monthly cost for coverage is listed below.

Coverage Category (select one)

☐ Employee Only	☐ Employee & Spouse[1]	☐ Employee & Child(ren)[1]	☐ Employee & Family[1]
	☐ Employee & Domestic Partner[2]	☐ Employee & Child of Domestic Partner[2]	☐ Employee & Domestic Partner & Child(ren)[1, 2]
$4.97	$8.29	$9.11	$13.26

ACCIDENTAL DEATH and DISMEMBERMENT (AD&D) INSURANCE

☐ I do not want AD&D coverage

If you want coverage, check one coverage category and one coverage amount below. If you enroll in coverage, see Part IV of this form for instructions on completing your beneficiary designation.

Coverage Amount (select one)	**Coverage Category** (select one)			
	☐ **Employee Only**	☐ **Employee & Spouse**[1]	☐ **Employee & Child(ren)**[1]	☐ **Employee & Family**[1]
☐ $10,000	$.16	$.22	$.19	$.22
☐ $20,000	.32	.44	.38	.44
☐ $30,000	.48	.66	.57	.66
☐ $40,000	.64	.88	.76	.88
☐ $50,000	.80	1.10	.95	1.10
☐ $60,000	.96	1.32	1.14	1.32
☐ $70,000	1.12	1.54	1.33	1.54
☐ $80,000	1.28	1.76	1.52	1.76
☐ $90,000	1.44	1.98	1.71	1.98
☐ $100,000	1.60	2.20	1.90	2.20
☐ $150,000	2.40	3.30	2.85	3.30
☐ $200,000	3.20	4.40	3.80	4.40
☐ $250,000	4.00	5.50	4.75	5.50

BASIC NON-CONTRIBUTORY LIFE INSURANCE

You are automatically enrolled in this Plan at no cost to you. The amount of insurance is two times your pay. See Part IV of this form for instructions on completing your beneficiary designation.

OPTIONAL CONTRIBUTORY LIFE INSURANCE

☐ I do not want Optional Age-Based Life Insurance coverage

If you want coverage, check a coverage level from 1 to 6 times your pay. This coverage is in addition to the Basic Non-Contributory Life Insurance the Company provides. Coverage in excess of $750,000 requires evidence of insurability and approval of Minnesota Life Insurance Company. If you enroll in coverage, see Part IV of this form for instructions on completing your beneficiary designation.

You must enroll in coverage for yourself before your spouse and/or child(ren) are eligible for coverage. Initial coverage for your spouse is in $10,000 increments up to $50,000. The cost of coverage for you and your spouse depends on your or your spouse's age and the amount of coverage you elect. You can enroll your child(ren) for $10,000, $20,000 or $30,000 of coverage; you pay one monthly rate for all eligible children.

Employee		**Spouse**[1]		**Children**[1]	
☐	1X	☐	$10,000	☐	$10,000
☐	2X	☐	$20,000	☐	$20,000
☐	3X	☐	$30,000	☐	$30,000
☐	4X	☐	$40,000		
☐	5X	☐	$50,000		
☐	6X	☐			

Contributory Life Insurance Rates

	Employee	**Spouse**	**Child(ren)**	
Age	Cost per $1,000 of coverage/mo.		Coverage	Cost/mo.
<25	$0.012	$0.012	$10,000	$0.76
25-29	$0.014	$0.014	$20,000	$1.52
30-34	$0.019	$0.019	$30,000	$2.28
35-39	$0.021	$0.021		
40-44	$0.023	$0.023		
45-49	$0.036	$0.036		
50-54	$0.054	$0.054		
55-59	$0.102	$0.102		
60-64	$0.156	$0.156		
65-69	$0.300	$0.300		
70+	$1.516	$1.516		

- To calculate Employee or Spouse monthly cost, divide the total coverage amount by $1,000. (Example: $60,000 ÷ $1,000 = 60)
- Multiply this number by the rate that corresponds to you or your spouse's age. (Example 60 x $.068 = $4.08. This is the monthly cost for coverage for this example.)

[1] Also complete "Part V: Dependent Information" on this form.

[2] Completion of the MOC 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.

LONG-TERM DISABILITY (LTD) PLAN

You are automatically enrolled in this Plan at no cost to you. If you become disabled and qualify for LTD benefits, payments will be 60% of your gross monthly pay, subject to a maximum monthly limit of $12,000.

OCCUPATIONAL ACCIDENTAL DEATH (OAD) BENEFIT PLAN

You are automatically enrolled in this Plan at no cost to you. The amount of coverage is the greater of $500,000 or twice your gross pay from the Company in the 12 calendar months immediately prior to your death. See Part IV of this form for instructions on completing your beneficiary designation.

FLEXIBLE SPENDING ACCOUNTS

Limited Health Care Spending Account Annual Election $_____ Only available when enrolled in a Health Investment Plan Option This account uses pre-tax payroll deductions to pay for eligible dental and vision expenses not covered by other benefit plans. Minimum $120, maximum $2,600, annually.

Dependent Care Spending Account Annual Election $ _____

This account uses pre-tax payroll deductions to pay for predictable child/elder care expenses of your eligible dependents. Minimum $120; maximum $5,000, per family, annually ($2,500 if married and filing a separate tax return). This account is NOT for reimbursement of medical expenses.

HEALTH SAVINGS ACCOUNT (HSA)

The HSA will be administered by Fidelity. **Note: You must be enrolled in a Health Investment Plan Option in 2018 to participate in an HSA. To enroll in the HSA participants will need to open this account with Fidelity before contributions can be made by Marathon Oil or the employee.**

Annual Election $ _____

This account uses pre-tax payroll deductions to pay for eligible predictable health, dental, vision and prescription drug expenses. **For HIP Value** Employee only maximum contribution is $2,950 annually and Employee + maximum contribution is $5,850 annually. **For HIP Plus** Employee only maximum contribution is $2,700 annually and Employee + maximum contribution is $5,350 annually **(If you are age 55 or older, you can elect to contribute an additional $1,000.)**

Part III: Signature

I authorize the elections I have made on this form. I also authorize that my compensation be reduced by an amount equal to my contributions for coverage under any or all of the applicable benefit plans above and be applied by the Company toward payment of such contributions for the applicable pay period. I direct that any contributions required of me be deducted from my gross pay according to applicable payroll procedures.

Employee Signature _____ Date _____

Part IV: Beneficiary Designations

All employees should make a beneficiary designation for the Basic Life Insurance and Occupational Accidental Death Benefit Plans. If you enrolled in the Optional Contributory Employee Life Insurance and/or Accidental Death & Dismemberment Insurance Plans, you should also designate a beneficiary for those plans.

Minnesota Life Insurance Company is our group life insurance provider. In the next few weeks, Minnesota Life will send a Welcome letter to your home address with instructions on making your beneficiary designations. Please take the time to complete this very important step in your new benefits with Marathon Oil Company.

If you do not receive the Welcome letter within 30 days of your hire date, please contact Minnesota Life at 1-866-293-6047.

AFFIRMATION FOR ELIGIBLE DEPENDENT(S) ON PAGE 4.

EMPLOYEE NAME_____ EMPLOYEE NO._____

Part V: Dependent Information

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 – 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, provide their Employee Number_____

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 2 – CHILD INFORMATION

A child dependent must be under the age of 26. **An adult child is eligible for coverage as a dependent in the applicable Marathon Oil Company Plans.** 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, a child placed with you for adoption, or a 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[B]	Gender (M/F)	Relationship (1, 2 or 3)	"X" if Disabled Age 26+
				- -			
				- -			
				- -			
				- -			

[B] 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, 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

Date Received by Company_____

Employee Number of Company Rep._____

Name of Company Rep._____

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