Marathon Petroleum Company LP

Employee Benefit Plans Enrollment/Change Form

A. EMPLOYEE PERSONAL INFORMATION

Last Name	First Name	MI	Effective Date

Social Security Number	Employee Number	Spouse Employee Number (Provide if spouse is MPC employee)	Daytime Telephone

B. ENROLLMENT/CHANGE REASON

Indicate the reason that you are enrolling for (or changing) your benefits and the date of the event that qualifies you to make this change. New hires and newly eligible employees have 60 days to enroll. If you are changing your benefits due to a qualifying event, you have 60 days from the event date to make the change. Your new election must be on account of the event and must correspond with the gain or loss of coverage.

1. Enrollment/change reason

- ❒ New hire
- ❒ Transfer from Speedway
- ❒ Casual hire (Medical enrollment only)
- ❒ Open enrollment
- ❒ Change in employment status
- ❒ Rehire/transfer Date: _____
- ❒ Leave of absence Type: _____
- ❒ Qualifying life event; check the box in Section 2 (to the right) describing the qualifying event. Indicate name of person who incurred the event: _____

2. Qualifying life event (supporting documentation is required)*

- ❒ Marriage/domestic partner
- ❒ Divorce/legal separation or termination of Domestic partnership
- ❒ Change in spouse/domestic partner employment status
  - ❒ Began/Terminated employment
  - ❒ Temporary to regular status
- ❒ Qualified medical child support order or similar court judgment
- ❒ Birth, adoption or placement for adoption
- ❒ Death of a dependent
- ❒ Other – subject to Benefits Service Center Approval (please explain):

_____

_____

_____

* Requested changes are generally effective the later of the date of the event or the date this form and any supporting documentation is received by the Benefits Service Center.

C. BENEFIT PLAN ELECTIONS

Dental

Plan
- ❒ Waive
- ❒ Dental PPO

Coverage Level
- ❒ Employee
- ❒ Employee + Spouse
- ❒ Employee + DP
- ❒ Employee + Child(ren)
- ❒ Employee, Spouse and Child(ren)
- ❒ Employee, DP and Child(ren)

Medical

Plan
- ❒ Waive
- ❒ Classic Option
- ❒ Saver HSA Option

Coverage Level
- ❒ Employee
- ❒ Employee + Spouse
- ❒ Employee + DP
- ❒ Employee + Child(ren)
- ❒ Employee, Spouse and Child(ren)
- ❒ Employee, DP and Child(ren)

Vision

Plan
- ❒ Waive
- ❒ Vision PPO

Coverage Level
- ❒ Employee
- ❒ Employee + Spouse
- ❒ Employee + DP
- ❒ Employee + Child(ren)
- ❒ Employee, Spouse and Child(ren)
- ❒ Employee, DP and Child(ren)

Accidental Death and Dismemberment*

Plan
- ❒ Waive
- ❒ $10,000
- ❒ $20,000
- ❒ $30,000
- ❒ $40,000
- ❒ $50,000
- ❒ $60,000
- ❒ $70,000
- ❒ $80,000
- ❒ $90,000
- ❒ $100,000
- ❒ $150,000
- ❒ $200,000
- ❒ $250,000

Coverage Level
- ❒ Employee
- ❒ Employee + Spouse
- ❒ Employee + Child(ren)
- ❒ Family

Employee Life*

Plan
- ❒ Waive
- ❒ 1x
- ❒ 2x
- ❒ 3x
- ❒ 4x
- ❒ 5x
- ❒ 6x annual pay

New Hires: Evidence of insurability is required for coverage in excess of $750,000.

Open Enrollment: You may only increase coverage by one level (1x annual pay). Evidence of insurability is required for coverage in excess of $750,000.

Dependent Life*

Spouse
- ❒ Waive
- ❒ $10,000
- ❒ $20,000
- ❒ $30,000
- ❒ $40,000
- ❒ $50,000
- ❒ $60,000
- ❒ $70,000
- ❒ $80,000
- ❒ $90,000
- ❒ $100,000

Child(ren)
- ❒ Waive
- ❒ $10,000
- ❒ $20,000
- ❒ $30,000

Newly Eligible: Coverage is limited to $50,000.

Open Enrollment: You may only increase coverage by one level ($10,000).

Newly Eligible or Open Enrollment: No coverage restrictions.

* Employees transferring from Speedway will not make any election; Speedway coverage amounts will automatically transfer to MPC Life and AD&D plans.

Health Care Flexible Spending Account (not available with Saver HSA Option)

- ❒ Waive
- ❒ Annual contribution: $ _____

(Minimum $120 per year; Maximum $2,600 per year)

Health Savings Account (HSA)

Please contact Fidelity at 1-800-544-3716 or visit www.fidelity.com/heathsavingsaccount

For complete information on MPC benefit plans and contribution amounts, visit www.mympcbenefits.com.

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Employee Last Name	First Name	MI	Social Security Number	Employee Number

D. DEPENDENT INFORMATION

Action	Name (First, MI, Last)	Relationship*	Birth Date (mm/dd/yyyy)	Social Security Number	Sex M F	Dental Y N	Medical Y N	Vision Y N	AD&D Y N	Life Y N
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒
❒Add ❒Drop					❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒	❒ ❒

*** Spouse, Domestic Partner, Child or Step-Child. If other, please specify. You must provide documentation on each dependent (e.g., birth certificate, marriage license, etc.). If enrolling a Domestic Partner, attach a completed Domestic Partner Affidavit along with required documentation. Requested changes will not be processed until documentation is received by the Benefits Service Center.**

E. AUTHORIZATION

I certify that the information I have provided 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 of my dependents. I understand that it is my responsibility to report to the Company any changes in the eligibility of my dependents within 60 days of such change(s).

I agree to be governed by the terms and conditions of the plans in which I have enrolled. I understand that if my initial enrollment is received by the Company prior to my first day of employment, coverage elected is generally effective on my first day of employment. If my initial enrollment is received on/after my first day of employment, but within my 60-day initial enrollment period, coverage elected is generally effective on the date my enrollment is received by the Company. Likewise, if my requested change due to a qualifying event is received prior to the date of the qualifying event, the requested change is effective on the date of the qualifying event. If my requested change is received on/after my qualifying event, but within my 60-day change period, coverage changed is generally effective on the date my change is received by the Company.

I authorize the Company to deduct pretax and/or after-tax contributions from my earnings now or in the future as required under each of the plans. I also understand that if my paycheck is not sufficient to cover my contributions, the Company may, in its sole discretion, automatically collect any such payment(s) from a future paycheck(s).

Employee Signature	**Date**	**For HR/Benefits Service Center Use Only**

Human Resources/Benefits Service Center Use Only

Effective Date	Approved By	Date Received	Notes
	Date	Data Entry Date/Processor	

Properly completed forms along with any required documentation should be submitted to the MPC Benefits Service Center

Email: benefits@marathonpetroleum.com
Phone: 1-888-421-2199
FAX: 1-419-421-3057
Mail: Room 3105, 539 South Main Street, Findlay, OH 45840