AMERCO® Medical Plan

Alternative Coverage Program Rebate Form (2014)

Purpose:
U-Haul will pay a monthly $75 rebate to team members who help control the cost of the AMERCO Medical Plan who have medical coverage elsewhere and reject medical coverage under the AMERCO Medical Plan.

To be eligible for the rebate:

1. You must be a full-time team member eligible for full-time benefits.
2. You must have a legal spouse (spouse must be of opposite gender).
3. Your spouse cannot be eligible for medical coverage through their employer.
4. You must reject medical coverage under the AMERCO Medical Plan.
5. You must be enrolled in a medical plan from another source (excluding benefits from a spouse's employer), such as but not limited to a second employer, a private policy, TRICARE, and ChampVA.

Required Documentation:

Provide documentation of proof of other coverage. Examples of valid documentation may include:

- Copy of your medical card,
- A letter from your insurance carrier verifying your coverage, or
- A copy of your enrollment confirmation.

Instructions:

Team member must complete an online benefit enrollment form (uhaulhr.com) rejecting the AMERCO Medical Plan Coverage.

Complete, sign and return this form and documentation.
By Email: benefits@uhaul.com
By Fax: (602) 760-4921

By Mail: U-Haul International, Inc.
Human Resources - Benefits Division
P.O. Box 21502
Phoenix, AZ 85036-1502

Team Member Information:

Name: _____ SMID: _____

Company/Department: _____ Work State: _____

Work Phone: _____ Home Phone: _____

Insurance Carrier: _____ Plan Name: _____

Address: _____ Effective Date: _____

City: _____ State: _____ Zip: _____ Plan Year: _____
(example: Jan. - Dec., Apr. - Mar.)

Cost: (if applicable) $_____ ☐ weekly ☐ biweekly ☐ semi-monthly ☐ monthly

---

I certify that the information provided is true and complete to the best of my knowledge. I understand that falsification and/or omissions on this form is a violation of company policy and may result in loss of benefits or be grounds for my immediate termination*. I also understand that if circumstances change and the information provided on this form needs to be updated, I must immediately notify the U-Haul Human Resources-Benefits Division of those changes. **If approved the monthly rebate will be effective the first of the month following verification.** The rebate will appear on the first payroll check of each month (please note that the rebate is considered taxable income).

I authorize U-Haul Human Resources - Benefits Division to contact the Insurance Carrier listed above to verify that the information I provided for my medical coverage is correct.

Team Member's Signature: _____ Date: _____

* This statement does not modify the company's "at-will" employment status.