Driver Registration Form

Please remember to include a photocopy of the driver's license and vehicle insurance when submitting this form. Forms submitted without these attachments will not be approved.

DRIVER DETAILS (Submit a photocopy of the driver's license)

First Name	Last Name	
Driver's License Number	Expiration Date (MM/DD/YYYY)	Issuing State
Email Address		Phone Number

VEHICLE INSURANCE INFORMATION (Submit a photocopy of active vehicle insurance)

Vehicle Insurance Number	Expiration Date (MM/DD/YYYY)

PAYMENT INFORMATION (Please only select one payment option)

☐ **Direct Deposit** *RECOMMENDED
Expect to receive payment in 1-2 weeks

Bank Account Type: ☐ Savings ☐ Checking	
Account Holder Name	
Routing Number	Account Number

☐ **Physical Check**
Expect to receive payment in 4-6 weeks

Mailing Address	
City	State
Zip Code	

DRIVER AGREEMENT FOR MILEAGE REIMBURSEMENT

I understand that I am a HUSKY Health Medicaid member providing my own transportation to an appointment or I am voluntarily providing transportation to assist a HUSKY Health Medicaid member. I attest that I own the vehicle, and if I do not own the vehicle, that I have permission from the vehicle owner to use the vehicle to provide transportation to assist either myself or a HUSKY Medicaid member. I also attest that the vehicle meets all insurance requirements under Connecticut state law and I understand and agree that it is my responsibility to follow all laws governing vehicles and drivers. I assume all responsibility for any and all risk of accident, automotive damage or bodily injury that I or the passengers may sustain while driving the HUSKY member.

I further understand that if the member, or any accompanying person, is under the age of 18 it is my responsibility to know and comply with State law regarding child seats, booster seats, seat belts, and/or requirements to have these minors sit in the rear seat.

Further, I, for myself and my heirs, executors, administrators and assignees, hereby release, waive, and discharge HUSKY Health and Veyo LLC, and its officers, directors, employees, and agents of and from any and all claims which I, my heirs, administrators or assignees ever may have against any of the above for, on account of, by reason of, or arising in connection with providing this service, and hereby waive all such claims, demands, and cases of action.

I understand that my only payment for these services will be mileage reimbursement, and that I will receive payment after submitting a complete and approved claim.

DRIVER AGREEMENT
I certify that I have read and agree to the above the above terms and conditions:

Signature _____ Date _____

Please submit completed forms by email, mail, or fax:

Email:
ctmileage@veyo.com

Fax: 860-218-2948

Mail: Veyo
Attn: Mileage Reimbursement
PO Box 1070
Windsor, CT 06095