WAIVER OF GROUP HEALTH INSURANCE

Employee's Names: *(Last, First, Middle)* _____ Date: _____

Department: _____ Title: _____

Driver's License #: _____ State: _____

Date Ticketed: _____ Citation #:_____

Type of Traffic Violation: _____

Resolution of Citation: _____

Vehicle Operated (check one): ☐ Personal ☐ City ☐ Other

Was Vehicle a Commercial Motor Vehicle? ☐ Yes ☐ No

Location of Offense (City/County): _____ State: _____

Issuing Agency: _____ _____

Did Violation Result in Loss of Driving Privileges? ☐ Yes ☐ No

If Yes, Please Explain:

_____

_____

_____

_____ _____

Employee Signature Date

Supervisor: *Send to the Human Resources Department within 24 hours of receipt.*