Trinidad Navarro
Insurance Commissioner

Delaware Department of Insurance

Delaware Quality Improvement Strategy Workgroup Designation Form

Designation Information	
Company Name:	**Date:**

Primary Contact			
Name:		**Title:**	
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**Email Address:**		

_____ _____

Primary Contact Signature ***Date***

Alternate Contact			
Name:		**Title:**	
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**Email Address:**		

_____ _____

Alternate Contact Signature ***Date***