AmeriHealth

Group Health Plan Designated Contact Form

Please complete all information and return to your marketing representative.

Group Customer Name: _____

Group Health Plan Designee Name: _____

OR

Group Health Plan Designee Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

I certify that the person or title listed above is an employee of the group health plan or the plan sponsor. This designation will remain in effect unless revoked or changed, in writing to AmeriHealth, by an authorized officer of the group customer.

Name: _____

Authorized Signature: _____

Title: _____

Date: _____

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