



SHIBA Volunteer Application

Thank you for your interest in becoming a SHIBA volunteer!

SHIBA mission statement:

The Statewide Health Insurance Benefits Advisors (SHIBA) provides free, unbiased information about health care coverage and access to help improve the lives of all Washington state residents. We cultivate community commitment through partnership, service, and volunteering.

SHIBA provides equal opportunities without regard to race, creed, color, religion, national origin, gender, sexual orientation, gender identify/expression, age, familial status, marital status, physical or mental disability or veteran’s status.

Please write legibly – use ink:

Personal information:

First name Last name

City County Zip code

()
Best phone number

Screening process

Because your volunteer capacity with SHIBA may involve unsupervised access to vulnerable adults and/or developmentally disabled people, all prospective volunteers, including in-kind staff, will receive a national level criminal background check.

Prospective volunteers will receive an email invitation to complete the authorization for the background check.

SHIBA will not conduct background checks or process applications until prospective volunteers have been in contact with the volunteer coordinator from their local SHIBA sponsor.



SHIBA Volunteer Agreement

The purpose of this agreement is to ensure a common understanding between the sponsor organization, the Washington State Office of the Insurance Commissioner (OIC), the Statewide Health Insurance Benefits Advisors (SHIBA) and the volunteer.

Volunteer name: First/MI/Last (please print legibly)

SHIBA Sponsor Organization name

County

I agree to the following:

I understand SHIBA is a consumer education, assistance and advocacy service of the OIC and the sponsor agency, not a policy creating or lobbying organization.

Non-affiliation – Conflict of interest

I do not have an active insurance license. I will act in good faith without selling, recommending or endorsing any specific insurance product, agency, or related service. Nor am I currently affiliated with or employed by a health insurance company, agency, or service, nor am I in a position to sell or receive commissions from health insurance products or services, or use my SHIBA affiliation for purposes of personal financial gain.

Impartiality

If in the future I become affiliated with an insurance company, agency or service, or I'm in a position to use my SHIBA affiliation for personal financial gain, I will terminate my position with SHIBA. Also, I remain impartial, refraining from advising or expressing my opinions regarding a consumer's course of action.

Confidentiality

I will not disclose any identifying client personal information to anyone outside the SHIBA organization without the client's authorization in accordance with state and federal laws.

Non-discrimination

I understand the act of favoritism or making a difference in treatment based on an individual's race, creed, color, religion, gender, nation origin, age, sexual orientation, gender identity, expression, familial status, marital status, physical or mental disability, political party or veteran's status is not permitted.

SHIBA Volunteer Agreement

Lobbying

I agree that I will not use public resources for political campaigns, to support or oppose candidates, ballot issues, or political causes. No one may use or authorize the use of facilities of an agency, directly or indirectly, for the purposes of assisting a campaign for election of a person to an office or for the promotion of or opposition to a ballot proposition. Resources include, but are not limited to, stationary, postage, machines, equipment, state employees or volunteers during working hours, vehicles, office space, publications of the agency, and clientele lists of people served by SHIBA or the OIC.

Volunteer (print name)

Volunteer signature

Volunteer coordinator (print name)

Volunteer coordinator signature

Date (MM/DD/YYYY)

Date (MM/DD/YYYY)

****PLEASE NOTE: APPLICATION CANNOT BE PROCESSED WITHOUT VC SIGNATURE***

****** This section to be completed by the volunteer coordinator ******

Partner organization affiliation: _____

Role: Volunteer – unpaid In-kind paid by partner organization.

Personal information:

Name (First/MI/Last)		Nickname or preferred name	
Mailing address			
City		State	Zip code
County	Phone ()		

Email address

Demographic information

Date of birth (MM/DD/YYYY): _____

Gender: Male Female Decline to disclose

Race/ethnicity:	Primary language:	Secondary language:
<input type="radio"/> American Indian/Alaska Native	<input type="radio"/> English	<input type="radio"/> English
<input type="radio"/> Asian	<input type="radio"/> Chinese	<input type="radio"/> Chinese
<input type="radio"/> Black or African American	<input type="radio"/> Korean	<input type="radio"/> Korean
<input type="radio"/> Hispanic or Latino	<input type="radio"/> Russian	<input type="radio"/> Russian
<input type="radio"/> Native Hawaiian/other Pacific Islander	<input type="radio"/> Spanish	<input type="radio"/> Spanish
<input type="radio"/> White	<input type="radio"/> Vietnamese	<input type="radio"/> Vietnamese
<input type="radio"/> Other:	<input type="radio"/> Other:	<input type="radio"/> Other
<input type="radio"/> Decline to disclose		

OIC media consent and release form

I authorize the Washington State Office of the Insurance Commissioner (OIC) to publish photos, videos, audio recordings, and any other media that includes my voice, image or any other identifier, collectively referred to as "media" in this consent and release form. I authorize my name and likeness for use in the OIC's print, online, social media and video-based marketing materials, along with other agency publications before or after modifying.

I release and hold harmless the OIC from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge my participation is voluntary and I will not receive financial compensation of any type associated with the taking or publication of these photos or participation in agency marketing materials other agency publications. I acknowledge and agree publication of said photos confers no rights of ownership or royalties whatsoever.

I release the OIC, its contractors, employees and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed name: _____

Signature: _____ **Date:** _____

Street address: _____

City: _____ **State:** ____ **Zip:** _____

Email address: _____