



INFORMATION | RESOURCES | ADVOCACY

PO Box 2308
Silverthorne, CO 80498
p:970.468.0295

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SHIP Volunteer Medicare Counselor Application

Thank you for your interest in the Colorado Senior Health Insurance Program (SHIP). Please complete all information to the best of your ability

*Please note we cannot accept applications from current insurance agents, brokers, or financial planners if license are still active due to conflict of interest.

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address: _____

Email Address: _____

Phone: (Home) _____ (Cell) _____

❖ Skills and Interests – please check all that apply

- One on one direct client services
- Writing articles
- General Office work
- Public Relations/Communications
- Teaching and Education
- Graphic Design/Web development
- Data entry
- Other

❖ Why are you interested in volunteering with the Medicare Counseling team?

❖ What applicable experience do you have? Please include paid or unpaid roles and include company names.

❖ Available hours per Month – please check one

- 4 hours or less
- 5 hours to 10 hours
- 10 + hours



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Do you have a personal laptop? Yes No

Do you have reliable internet? Yes No

❖ **Conflict of interest**

Are you affiliated with any of the following:

- Yes No Insurance company, agency, broker, financial planning service
- Yes No Health Insurance claims, Billing service, law firm of legal service
- Other:

❖ **Declaration**

I understand that volunteerism is a privilege, not a right, and that my placement in a volunteer position is conditional upon successfully completing the application, screening, and training requirements.

Initials _____

I understand that as a volunteer, I do not work for any member County or NWCCOG as an employee; therefore, I am not entitled to workers' compensation benefits and will not be provided any lost wages or permanent disability benefits for my regular employment.

Initials _____

I declare that the information provided and statements made in this application are true and complete to the best of my knowledge and belief.

Initials _____

I understand that the purpose of the training I receive as a Medicare Navigator is to provide services free of charge to Medicare beneficiaries and is not to be used for y personal monetary gain.

Initials _____

I understand that Vintage will run a Colorado Bureau of Investigations CBI background check on me.

Initials _____

Volunteer Signature _____ **Date** _____

❖ **Emergency Contact**

Name: _____

Relationship: _____ Telephone: _____

Please return form to: Jonnah Glassman jglassman@nwccog.org For questions please call 970-315-1328