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.

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.

OFFICE of the INSURANCE COMMISSIONER
SHIBA WASHINGTON STATE

SHIBA Resource Record

Please write legibly – use ink!

Personal information

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

Demographic information

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

Do you consider yourself to be transgender? ☐ Yes ☐ No ☐ Prefer not to answer

Gender: (please select one)	**Sexuality: (please select one)**
❍ Man	❍ Lesbian or gay
❍ Woman	❍ Straight, that is, not gay or lesbian
❍ I use a different term	❍ Bisexual
❍ Non-binary	❍ I use a different term
❍ I prefer not to answer	❍ I don't know
	❍ I prefer not to answer

Race/ethnicity:	**Primary language:**	**Secondary language:**
❍ American Indian/Alaska Native	❍ English	❍ English
❍ Asian	❍ Chinese	❍ Chinese
❍ Black or African American	❍ Korean	❍ Korean
❍ Hispanic or Latino	❍ Russian	❍ Russian
❍ Native Hawaiian/other Pacific Islander	❍ Spanish	❍ Spanish
❍ White	❍ Vietnamese	❍ Vietnamese
❍ Other:	❍ Other:	❍ Other
❍ Decline to disclose		