Print Form

DELAWARE SHIP, 841 SILVER LAKE BLVD. DOVER, DE 19904
TELEPHONE: 1.800.336.9500 OR 302.674.7364 FAX: 302-739-6278

SHIP VOLUNTEER APPLICATION

Name (First, Middle Initial, Last): _____

Mailing Address: _____

City: _____ Zip Code: _____

County of Residence _____ Date of Birth: _____

Telephone Numbers with area code (Home) _____ (Work) _____

(Cell) _____ (Fax) _____

Can we send correspondence through e-mail? ☐ Yes ☐ No
If so, email address: _____

Are you or any of your immediate family members a licensed insurance agent? If so, give full name and relationship _____

Have you ever been convicted of an offense against the law other than a minor traffic violation? ☐ Yes ☐ No If yes, explain _____

Please list three references that we may contact.

Reference 1: _____
(Name, Address, Telephone Number, Relationship)

Reference 2: _____
(Name, Address, Telephone Number, Relationship)

Reference 3: _____
(Name, Address, Telephone Number, Relationship)

How did you learn about becoming a SHIP Volunteer Counselor?

☐ Friend ☐ Newspaper/News ☐ Website
☐ Radio/TV ☐ Flyer ☐ Other _____

Are you a Medicare beneficiary ☐ Yes ☐ No

Gender: ☐ Male ☐ Female

Are you disabled? ☐ Yes ☐ No

Ethnicity (Please check one):

☐ American Indian or Alaska Native
☐ Black or Africa-American
☐ Native Hawaiian or other Pacific Islander
☐ Other
☐ Asian
☐ Hispanic or Latino
☐ White, not of Hispanic origin

What is the highest level of education you have achieved? (Please check one)

☐ Less than high school diploma
☐ High school diploma/GED
☐ Two-year/Associate degree
☐ Four-year degree
☐ Master's/Doctorate degree (please specify field)_____
☐ Other (please specify)

Which topics are you most interested in? (Check all that apply)

☐ General SHIP Information
☐ QMB/SLMB/QI-1
☐ State Pharmacy Assistance Program
☐ Medicare Health Plans (Medicare Advantage)
☐ Medicare Prescription Drug Coverage (PDP/ MA-PD)
☐ Medicare (Parts A & B)
☐ Other Prescription Drug Coverage/Assistance
☐ Medigap/Medicare supplemental

What skills do you have that you feel will be useful in your work as a SHIP volunteer counselor?

_____

_____

I, _____, agree to serve as a Volunteer Counselor for the State Health Insurance Assistance Program (SHIP). As a volunteer Counselor, I will try to help persons in my community with their questions and problems regarding Medicare, Medicare supplements, and care Advantage/Health plans (if available).

While providing such volunteer services, I understand that I may not endorse any particular insurance company, insurance agent or other private provider of health insurance. I will also keep all consultations confidential, except for filing reports with SHIP staff.

I further agree to provide volunteer services without compensation, reimbursement of expense or financial remuneration of any kind.

_____

Prospective SHIP Volunteer Counselor's Signature

Start date of basic training: _____

Completion date of basic training: _____

References Verified (Staff Initials):