



SHIP

Volunteer Counselor Application

Send Completed Applications to: Aging.SHIP@illinois.gov or mail to:
Senior Health Insurance Program (SHIP), Illinois Department on Aging, One Natural Resources Way #100 Springfield, IL. 62702-1271

Your County: _____

If known, name of SHIP site you will be volunteering from:

Name: _____

Street Address: (where SHIP mail is to be delivered) _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ Work Phone: () _____

Email Address (mandatory): _____

Present Occupation & Place of Employment: _____

Former Occupation: _____

How did you learn about SHIP? _____

Circle One

Do you have any affiliation with any insurance company or entity? Yes No

Are you affiliated with a claims filing service? Yes No

Are you affiliated with a financial planning service? Yes No

Do you intend to use this training for financial gain? Yes No

If you answered yes to any question above, please explain:

(see reverse side)

Computer skills (i.e., internet, Word, Power Point, Excel, etc.):

Please list any volunteer programs and/or organizations in which you are currently involved:

Other Information (i.e., education, professional qualifications, special skill, etc):

Other languages spoken: _____

If known, which SHIP training do you plan to attend?

Dates: _____

Location: _____

I, the undersigned, declare the statements made in this application are true, correct and completed to the best of my knowledge and belief. I also declare that I understand the purpose of the training I will receive from the Senior Health Insurance Program (SHIP) is to provide **volunteer** services to Medicare beneficiaries and I will not use this information for my personal monetary gain.

Signature: _____ Date: _____

For Office Use Only

Approved: _____ Disapproved: _____ Date: _____