



Application

Name:		Home phone: ()		Work phone (if applicable): ()	
Address:		County:		Fax number (if available): ()	
Street: _____ _____		E-mail address (if available):			Sex:
City: _____		Date of birth: / /		Spouse's name (optional, if applicable):	
State: _____		Ethnicity/race (optional)			
Zip: _____		___ Native American/Alaskan Native		___ Asian	
		___ Black, African-American		___ Hispanic/Latino	
		___ White, Non-Hispanic		___ Other	
I'm interested in the following position(s): <input type="checkbox"/> C ounselor <input type="checkbox"/> L eader in Outreach <input type="checkbox"/> A dministrative Support <input type="checkbox"/> I nterest Specialist <input type="checkbox"/> M entor			How did you hear about CLAIM? <input type="checkbox"/> Volunteermatch.com <input type="checkbox"/> Missouriclaim.org <input type="checkbox"/> Other website: _____ <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Newspaper/Newsletter <input type="checkbox"/> Other:		
CLAIM volunteers cannot work for insurance companies or sell insurance for at least one year prior to volunteering. They cannot potentially receive any financial gain from becoming a CLAIM volunteer counselor.					
Are you currently working in the insurance industry? ___ Yes ___ No If no, have you in the past 12 months? ___ Yes ___ No If yes, what were your responsibilities?					
Current occupation:			If retired, former occupation:		
Education or course of study:					
Community service activities (include board memberships and all volunteer activities):					

Please complete both sides.

Why do you want to be a volunteer?

Would you be willing to make a minimum commitment of six hours/month for six months?
___ Yes ___ No

Do you speak any languages other than English? ___ Yes ___ No If yes, please list them:

Have you ever been convicted of a felony? ___ Yes ___ No
If yes, please explain.

Please list three references.

Name: _____ Relationship: _____
Phone: _____ Email: _____
Check one: ___ work ___ home

Name: _____ Relationship: _____
Phone: _____ Email: _____
Check one: ___ work ___ home

Name: _____ Relationship: _____
Phone: _____ Email: _____
Check one: ___ work ___ home

Signature of applicant _____ Date: / /



Please return completed application to:
CLAIM
200 North Keene Street
Columbia, MO 65201
Fax: 573-817-8341
Email: claim@primaris.org



DIFP
Department of Insurance,
Financial Institutions &
Professional Registration