



To ALL Oregon SHIBA Clients
Disclosure Statement



The Oregon Senior Health Insurance Assistance (SHIBA) Program is sponsored by the Oregon Insurance Division of the Department of Consumer and Business Services in order to make information on health insurance more widely available to, and understandable for, Oregonians with Medicare. Should you have further questions regarding SHIBA, please call 800-722-4134

SHIBA, and SHIBA Counselors **CAN**:

- Provide you with information on Medicare benefits, Medicare Supplement plans, Medicare Advantage plans, Prescription Drug Plans, Long-Term Care insurance and other kinds of health insurance programs and policies.
- Give you helpful information on how you can compare insurance products and the benefits they provide.
- Assist you in analyzing the different kinds of policies and insurance programs in which you have an interest.
- Assist with applications for “Extra Help” prescription drug subsidy, research Patient Assistance Programs and make appropriate referrals to agencies that provide help with Medicare costs.
- Help you to identify resources (government offices, public service agencies, insurance agents or other information resources) you may need to consult before making decisions. SHIBA counselors have been trained to deal with commonly raised questions in these areas.

SHIBA, and SHIBA Counselors **CANNOT**:

- Advise you on the purchase, renewal or termination of specific insurance products or programs.
- Endorse any particular insurance policy, program, agent or company.
- Provide legal advice.
- Make decisions for you.

By my signature below, I acknowledge that SHIBA and /or SHIBA Volunteers are providing service to me based on the above statements.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

IF NEEDED, PLEASE COMPLETE:

_____(initial here) Furthermore, I authorize the SHIBA Sponsoring Organization (_____) to obtain information as necessary directly from my hospital, physician or other supplier of medical services or supplies to complete the filing of my medical claim to Medicare or of _____ other insurance plans. This authorization shall remain valid for 90 days from the date of signature unless earlier revoked in writing.