



Consent/Understanding of  
Changes to Insurance



I am currently on or have the option to join a retirement health insurance program. I understand if I leave a my employer-sponsored Medicare plan I will forfeit any future opportunity to enroll in it again.

Client Name \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

SHIBA Counselor \_\_\_\_\_



Consent/Understanding of  
Changes to Insurance



I am currently on or have the option to join a retirement health insurance program. I understand if I leave a my employer-sponsored Medicare plan I will forfeit any future opportunity to enroll in it again.

Client Name \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

SHIBA Counselor \_\_\_\_\_