FHFA Enrollment Form

Employee Name: _____

Date of Birth: _____ **Last 4 of SSN:** _____

Address: _____ **Is this a new address?**

_____ ☐ Yes ☐ No

Type of Enrollment:

☐ New Enrollment ☐ Cancel Dependents Only

☐ Add Dependents ☐ Cancel All Coverage

Type of Coverage: ☐ Employee Only ☐ Employee + 1 ☐ Employee + Family

Eligible Family Members:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature **Date**

OHRM Use Only

Unique ID Number: _____

Effective Date: _____