

**Flexible spending account (FSA)
employee enrollment form**



Please return this form to your HR department.

Employer information	
Employer name	Murray Company

Account holder information			
First name	M.I.	Last name	
SSN	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mm/dd/yyyy)	
Email address		Home phone	
Physical street address	City	State	ZIP
Mailing address (if different)	City	State	ZIP

FSA coverage	
Coverage effective date	1-1-2023

Annual elections				
	Contribution per pay period	Number of pay periods remaining in plan year	=	Your annual election amount
Flexible spending account	\$	X	=	\$
Limited purpose flexible spending account (LPFSA)	NA	NA	=	NA
Dependent care flexible spending account (DCRA)	\$	X	=	\$
Contribution per pay period x number of pay periods = your annual election amount				

Signature <input type="checkbox"/> I decline to participate in the FSA plan.		
Print name	Signature	Date