

Flexible Spending Account Plan(s) Worksheet

Dependent Care Assistance: \$ _____ x _____ = _____ (A)
Weekly Expense # of Weeks TOTAL COST

(How much do you pay for child care for children under 13 years, including child care centers, pre-school, summer day camp, family day care, after school programs, and church programs)

NUMBER OF PAY PERIODS _____ (B)
 (from date of election to end of current plan year)

AMOUNT OF REDIRECTION PER PAY PERIOD _____ (A/B)

AMOUNT OF REDIRECTION PER PAY PERIOD \$ _____

Medical Expense Reimbursement Account (Health FSA):

(Estimate your uninsured medical costs per year for you, your spouse, and/or dependent(s))

This list is not all inclusive.

	Projected Expenses
Insurance Deductibles	\$ _____
Insurance Co-payments	\$ _____
Dental Deductibles	\$ _____
Dental Expenses	\$ _____
Vision Deductibles	\$ _____
Vision Expenses	\$ _____
Hearing Expenses	\$ _____
Over-the-Counter Medications	\$ _____
Prescriptions	\$ _____
Psychologist	\$ _____
Medically required equipment	\$ _____
Chiropractic	\$ _____
Orthodontia	\$ _____
Physical Examinations	\$ _____
Surgery	\$ _____
Other Medical Expenses	\$ _____
TOTAL COST:	\$ _____ (A)

NUMBER OF PAY PERIODS _____ (B)
 (from date of election to end of current plan year)

AMOUNT OF REDIRECTION PER PAY PERIOD _____ (A/B)

AMOUNT OF REDIRECTION PER PAY PERIOD \$ _____

****You may meet with your benefits counselor to answer any questions and adjust your estimates according to your personal needs****