Flexible Benefit Plan 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******