Flexible Spending Account Worksheet

Pay Check Deductions:

Group Medical Insurance	**$_____**
Group Term Life Insurance	**$_____**
Group Dental Insurance	**$_____**
Cancer, Intensive Care, Accident	**$_____**
TOTAL COST:	**$_____**

Dependent Care Assistance: $_____ x _____ = _____

(How much do you pay for dependent care for children under 13 years.)

Weekly Expense **# of Weeks** **Total Cost**

Medical Expenses:

(Estimate your uninsured medical costs per year)

	Projected Expenses
Insurance Deductibles	**$_____**
Insurance Co-payments	**$_____**
Dental Deductibles	**$_____**
Dental Expenses	**$_____**
Vision Deductibles	**$_____**
Vision Expenses	**$_____**
Hearing Expenses	**$_____**
Prescriptions	**$_____**
Medically required equipment	**$_____**
Chiropractic	**$_____**
Other Medical Expenses	**$_____**
TOTAL COST:	**$_____**

Individually Owned Health Insurance:

(Enter the annual premium amount of any of the following insurance plans that you or your dependents individually own)

Dental Insurance	**$_____**
Vision Insurance	**$_____**
Cancer Insurance	**$_____**
Intensive Care Insurance	**$_____**
Accident Insurance	**$_____**
TOTAL COST:	**$_____**

Total Deductions: $_____

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