# 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******