

## Flexible Benefit Plan Sample Worksheet

Estimate expenses that you and your family expect during the entire Plan Year that will not be reimbursed or covered by any health or dental insurance plan. An expense is considered to be **"incurred" on the date you receive the service - not the date you pay the bill.**

Dependent Day Care Expenses (CUSTODIAL CARE ONLY)	Monthly Expense	Plan Year Expense
Day Care Expense Incurred While You Work	<input type="text"/>	<input type="text"/>
Nursery School Fees	<input type="text"/>	<input type="text"/>
Before/After School Fees	<input type="text"/>	<input type="text"/>
Summer Day Camp	<input type="text"/>	<input type="text"/>
Total Dependent Day Care Expense	\$ <input type="text"/>	\$ <input type="text"/>

The total amount in which you may contribute to your Dependent Day Care Account may not be more than \$5,000 (\$2,500 if you are married and filing separate tax returns).

### Health Care Expenses

Medical Deductibles	<input type="text"/>	<input type="text"/>
Pharmacy Copays	<input type="text"/>	<input type="text"/>
Coinsurance Amounts	<input type="text"/>	<input type="text"/>
Vision Care	<input type="text"/>	<input type="text"/>
Routine Exams	<input type="text"/>	<input type="text"/>
Travel Costs related to Medical care	<input type="text"/>	<input type="text"/>
Medical appliances (wheelchairs, crutches, etc.)	<input type="text"/>	<input type="text"/>
Hearing Exams	<input type="text"/>	<input type="text"/>
Dental Deductibles/Coinsurance	<input type="text"/>	<input type="text"/>
Orthodontia Expenses	<input type="text"/>	<input type="text"/>
Other Eligible Expenses	<input type="text"/>	<input type="text"/>
Total Health Care Expenses	\$ <input type="text"/>	\$ <input type="text"/>

You may not enroll for a higher deduction than is allowed by the Plan and IRS rules. Also, you should be careful to contribute only that amount of your pay that you are reasonably sure you will spend during the Plan Year.