

Flexible Spending Account Worksheet
FOR EMPLOYEES

Pay Check Deductions:

Medical Expenses: Projected Expenses
(Estimate your uninsured medical costs per year)

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 (PPP):
(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. ****