

This is not an enrollment form. This worksheet is intended to guide you through the enrollment process.
This worksheet will help you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

Medical/Dental/Vision Reimbursement Account

Annual Medical Expenses, such as:

Deductibles and co-pays \$ _____
Routine physical exams \$ _____
Prescriptions \$ _____
Chiropractic care \$ _____
Other \$ _____

Annual Dental Expenses, such as:

Deductibles and co-pays \$ _____
Routine check-ups \$ _____
Orthodontia \$ _____
Other \$ _____

Annual Vision Care Expenses, such as:

Exams \$ _____
Eyeglasses \$ _____
Contact lenses, solutions, cleaners \$ _____
Other \$ _____

**Total Estimated
Medical/Dental/Vision Expenses** \$ _____ ÷ _____ = \$ _____
Annual Amount (cannot exceed company max.) # of Pay Periods* Per Pay Period

Dependent Care Reimbursement Account

Annual Dependent Care Expenses:

Payment to a dependent care facility
or individual \$ _____
Payment to other care providers \$ _____

**Total Estimated
Dependent Care Expenses** \$ _____ ÷ _____ = \$ _____
Annual Amount (cannot exceed \$5,000 IRS max.) # of Pay Periods* Per Pay Period

Total Per-Pay-Period Reduction \$ _____
(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.) Total Per Pay Period

*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods