Flexible Spending Enrollment Worksheet

The following is a worksheet to help you estimate the benefit amounts you should elect for the coming Plan Year. By going through this worksheet you should have a pretty good idea of what your annual budget for *unreimbursed* medical expenses and dependent care expenses will be. These are just some examples of qualifying expenses. This is not an all-inclusive list.

Medical Flexible Spending Account Expenses

Regular Monthly Cost

Monthly prescription costs	$_____
Diabetic Supplies	$_____
Contact Lens Supplies	$_____
Other Costs (_____)	$_____
Other Costs (_____)	$_____
Monthly Total	$_____

Monthly Total times the number of months participating (_____) = $_____

Expected One Time Costs

Medical and dental plan deductibles	$_____
Medical, dental, and vision plan co-payments	$_____
Other co-payments	$_____
Dentist exams and cleaning	$_____
Braces and other Orthodontia	$_____
Vision eye ware	$_____
Medically required health clubs and equipment	$_____
Wheelchair, crutches and other medical appliance	$_____
Smoking Cessation Program (only available by prescription)	$_____
Other Costs (_____)	$_____
Other Costs (_____)	$_____
Total	**$ _____**

Grand Total for Medical Expenses (see SPD for Plan maximum) $ _____

Dependent Care Assistance Plan Expenses (expected annual amounts)

Elder care	$_____
After school care	$_____
Regular day care	$_____
Nursery school prior to kindergarten	$_____
Summer day camp	$_____
Other Costs (_____)	$_____

Grand Total for Dependent Care Expenses *(limited to $5,000 per year)* $ _____

Number of pay cycles in one full year:

Weekly (W)= 52 **Biweekly (B) = 26**

Semimonthly (SM)=24 **Monthly (M) = 12**

Grand Total for Medical Expenses _____ (Total Expense) ÷ _____ (# paychecks/yr) = $_____ (Amount per pay period)

Grand Total for Dependent Care Expenses _____ (Total Expense) ÷ _____ (# paychecks/yr) = $_____ Amount per pay period

If you have any questions or need assistance call toll-free 800-232-1913 or email us at fsa_memberservices@cbca.com.

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