

Flexible Spending Account Worksheet

Medical Expense Reimbursement Account

Complete this worksheet to determine how much of your salary you should place into your Medical Expense Reimbursement Account.

Be as accurate as possible when recording last year's expenses and be conservative when estimating next year's expenses.

Any money you put into the program must be used exclusively for eligible unreimbursed medical expenses and you forfeit any money remaining in this program at the end of the year.

If you are covered by a dental plan, be sure to include only additional uninsured amounts beyond deductibles and coinsurance in Section 3.

If you don't have dental insurance, most medically necessary expenses are eligible for reimbursement.

Dependent Care Reimbursement Account

IRS regulations limit the amount you can contribute to a Dependent Care Reimbursement Account to \$5,000 for a married parent filing jointly or a head of household filer, and \$2,500 for a married parent filing separately.

The cost of a kindergarten program does not qualify if the program's purpose is primarily educational. Overnight camp expenses are not qualified expenses.

Only expenses necessary to provide care for a dependent while you are working are eligible for reimbursement.

Estimate expenses as accurately as possible. Any money left in your account cannot be returned to you.

SECTION 1: Deductibles and coinsurance

	Actual expenses last year	Expected expenses for coming year
How much do you and your spouse pay each year to fulfill medical and dental insurance deductibles?	_____	_____
How much do you and your spouse pay each year to fulfill medical and dental insurance coinsurance requirements?	_____	_____
Total annual cost for Section 1	_____	_____

SECTION 2: Other unreimbursed medical expenses

Routine exams	_____	_____
Prescription drugs	_____	_____
Vision care	_____	_____
Equipment/other expenses for the disabled	_____	_____
Treatment of mental/nervous conditions	_____	_____
Treatment of alcoholism or drug dependency	_____	_____
X-rays	_____	_____
Other uninsured medical expenses	_____	_____
Total annual cost for Section 2	_____	_____

SECTION 3: Other unreimbursed dental expenses

Exams and cleaning	_____	_____
Braces and retainers (only if medically necessary)	_____	_____
Fillings, crowns, bridges	_____	_____
X-rays	_____	_____
Dentures	_____	_____
Other uninsured dental expenses	_____	_____
Total annual cost for Section 3	_____	_____
Grand totals (last year and upcoming year) Section 1 + Section 2 + Section 3	_____	_____

SECTION 4: Dependent care expenses

Day care center	_____	_____
Nursery/preschool	_____	_____
Before/after school expenses	_____	_____
Dependent care expenses	_____	_____
Other dependent care expenses	_____	_____
Total annual cost for Section 4	_____	_____