

Worksheet for Determining Eligible Expenses you anticipate incurring During the Plan Year:

Un-reimbursed Health Account

Un-reimbursed Dependent Care

Account

Annual

Medical Care Expenses

Deductibles: Med \$ _____
Dental Coinsurance \$ _____
Dental \$ _____
Medical Coinsurance \$ _____
Vision \$ _____
Dental Expense
beyond maximum \$ _____
Co-pays: Med \$ _____
Ortho Expenses \$ _____
RX \$ _____

Dental \$ _____
Other \$ _____
Vision \$ _____
Other \$ _____

Special Equipment \$ _____

TOTALS:

Medical Travel \$ _____

Health Care Expenses \$ _____

Annual

Dependent Care Expenses

Day Babysitters \$ _____
Day Care Centers \$ _____
Elder Care \$ _____
Day Camp \$ _____
After School Program \$ _____
Nursery School \$ _____

TOTALS:

Medical Care Exp \$ _____

Dependant Care Exp \$ _____