

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 \$ _____

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

TOTALS:

Medical Care Exp \$ _____

Dependant Care Exp \$ _____

Annual

Dependent Care Expenses