



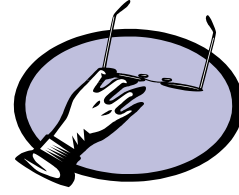
# HEALTHCARE FSA ANNUAL ELECTION WORKSHEET



**MEDICAL**



**DENTAL**



**VISION**

*When estimating eligible expenses, remember to include expenses for you AND your dependents for the whole plan year. Do not include expenses covered by your insurance plans.*

Office visit co-payments \$ \_\_\_\_\_

Prescription drugs for the plan year \$ \_\_\_\_\_

Vision exams \$ \_\_\_\_\_

Contact lenses, prescription glasses (lenses and frames) \$ \_\_\_\_\_

Contact cleaning supplies for the plan year \$ \_\_\_\_\_

Chiropractic services \$ \_\_\_\_\_

Physical exams \$ \_\_\_\_\_

Psychological services \$ \_\_\_\_\_

Dental expenses \$ \_\_\_\_\_

Orthodontic payments for the plan year (if on a payment contract) \$ \_\_\_\_\_

LASIK or PRK eye surgery \$ \_\_\_\_\_

Over-the-counter drugs, non-prescription pain relievers, allergy meds and cold/flu medications \$ \_\_\_\_\_

Annual health insurance deductible per person \$ \_\_\_\_\_

Annual dental insurance deductible per person \$ \_\_\_\_\_

**The following are NOT eligible: insurance premiums, massages, vitamins (except prescription pre-natal), herbs, nutritional supplements, teeth bleaching/whitening, cosmetic procedure/surgery.**

**Total Estimated Annual Expenses** \$ \_\_\_\_\_

**Per Pay Period Expenses** (divide annual by # of pay periods in plan year) \$ \_\_\_\_\_