

**Flexible Spending Account Deduction Worksheet**

**This is not an enrollment form.** This worksheet is intended to guide you through the enrollment process. This worksheet will help you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

**Medical/Dental/Vision Reimbursement Account**

.....**Annual Medical Expenses, such as:**

- Deductibles and co-pays \$ \_\_\_\_\_
- Routine physical exams \$ \_\_\_\_\_
- Prescriptions \$ \_\_\_\_\_
- Chiropractic care \$ \_\_\_\_\_
- Other \$ \_\_\_\_\_

**Annual Dental Expenses, such as:**

- Deductibles and co-pays \$ \_\_\_\_\_
- Routine check-ups \$ \_\_\_\_\_
- Orthodontia \$ \_\_\_\_\_
- Other \$ \_\_\_\_\_

**Annual Vision Care Expenses, such as:**

- Exams \$ \_\_\_\_\_
- Eyeglasses \$ \_\_\_\_\_
- Contact lenses, solutions, cleaners \$ \_\_\_\_\_
- Other \$ \_\_\_\_\_

**Total Estimated Medical/Dental/Vision Expenses** \$ \_\_\_\_\_ ÷ \_\_\_\_\_ = \$ \_\_\_\_\_  
Annual Amount # of Pay Periods\* Per Pay Period  
 (cannot exceed company max.)

**Dependent Care Reimbursement Account**

**Annual Dependent Care Expenses:**

- Payment to a dependent care facility or individual \$ \_\_\_\_\_
- Payment to other care providers \$ \_\_\_\_\_

**Total Estimated Dependent Care Expenses** \$ \_\_\_\_\_ ÷ \_\_\_\_\_ = \$ \_\_\_\_\_  
Annual Amount # of Pay Periods\* Per Pay Period  
 (cannot exceed company max.)

**Total Per-Pay-Period Reduction** \$ \_\_\_\_\_

(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.) Total Per Pay Period

Period\*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods