FLEXIBLE SPENDING ACCOUNT WORKSHEET

Qualifying Unreimbursed Health Expenses

Only expenses NOT reimbursed by insurance can be claimed:

Ambulance Hire
Artificial Limbs and Teeth
Automobile Modifications (hand controls, special equipment, mechanical lifts),
Braille books & magazines
Crutches
Drugs (Legal - prescription only or insulin) and medical supplies
Elastic hose, medically prescribed
Eyeglasses / Contact Lenses
Fees: Acupuncture
Anesthetist
Blood donor
Chiropodist
Chiropractor
Christian Science practitioners
Clinic
Dentist
Diagnosis
Diathermy
Examination, physical
Eye examination
Gynecologist
Healing services
Hospital
Laboratory
Lip reading lessons for the deaf
Medical information plan
Midwife
Nurse
Oculist
Ophthalmologist
Optician
Optometrist
Oral surgery
Osteopath
Pediatrician
Physician
Physiotherapist
Podiatrist
Practical Nurse
Psychiatrist
Psychologist
Surgeon
Halfway house residency
Hearing devices
Hospital bills
Iron lung, operating cost
Laetrile, when prescribed by doctor
Nursing care
Obstetrical expense
Oxygen equipment
Rental of medical or healing equipment
Seeing-eye-dog
Support or corrective devices (including special mattress and board for arthritis)
Telephone for deaf
Television set modifications to receive closed captions
Transportation expense relative to illness
Wheelchair
X-rays

Qualifying Dependent Care Expenses

Expenses incurred by you and, if married, your spouse to be gainfully employed:

- Expenses paid to a Dependent Care Center or care provider.
- Expenses paid for care of a Dependent under age 13.
- Expenses paid for care of a Dependent who is physically or mentally incapable of caring for himself.
- Must report Tax ID # or Social Security of provider for expenses to qualify.

If an item is not listed, please verify eligibility with the IRS or your accountant.

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

Unreimbursed Health Account

Annual

Deductibles: Med $_____
Dental $_____
Vision $_____

Copays Med $_____
RX $_____
Dental $_____
Vision $_____

Special Equipment $_____
Physicals $_____
Medical Travel $_____
Hearing Aides $_____
Vision, Glasses, Contact Lenses, Supplies $_____

Dental Coinsurance $_____
Medical Coinsurance $_____
Dental Expense beyond maximum $_____
Ortho Expenses $_____
Other $_____

TOTAL Health Expenses $_____

Unreimbursed Dependent Care Account

Annual

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

TOTAL Dependent Care Expenses $_____