FLEX Worksheet

HEALTH CARE REIMBURSEMENT ACCOUNT

Use this worksheet to estimate the health care expenses you expect to incur during the plan year, which will not be paid by insurance. Expenses incurred for your tax dependents can be included. Be conservative...remember, if you don't use it, you lose it.

Expense Categories	Sub-Category Amount	Category Total
Insurance Deductibles/Office Co-Pays		$
Medical	$	
Dental	$	
Coinsurance Payments		$
Medical	$	
Dental	$	
Vision Expenses		$
Eye Exams	$	
Prescription Glasses/Sunglasses	$	
Contact Lenses and Solutions	$	
Laser Surgery	$	
Prescription Medications		$
Over-the-Counter Medicines (require prescription)		$
Over-the-Counter non-medicinal items		$
Dental Expenses		$
Preventative Care (cleaning, fluoride etc.)	$	
Restorative (fillings, crowns, root canal etc.)	$	
Orthodontia (Monthly payments x 12)	$	
Hearing Aid and Batteries		$
Chiropractic Fees		$
Mental Health Counseling Fees (Family and marriage counseling are not eligible)		$
Other		$
	Total	$