FLEXIBLE BENEFITS PLAN ANNUAL EXPENSE WORKSHEET

		ANNUAL EXPENSE
PART I	Group Medical Insurance Premium Expenses Enter on the FLEXIBLE BENEFITS Enrollment Form under Medical Premium	$_____
PART 2	Medical Reimbursement Expenses	

Listed below are medical expenses you and your family may have that are not completely covered by insurance. Estimate your annual medical related expenses** not paid by group insurance for the upcoming plan year:

Allergy medicines	$_____
Antacids	$_____
Child Birth (portion not covered by insurance)	$_____
Chiropractor	$_____
Cold medicines	$_____
Contraceptives	$_____
Contact Lens Solution	$_____
Co-Payments	$_____
Dental Care Expenses (routine checkups, filings)	$_____
Deductibles	$_____
Fees to doctors, hospitals (not covered by insurance)	$_____
First aid creams	$_____
Hearing Aids	$_____
Immunization & inoculations	$_____
Incontinence supplies	$_____
In Vitro fertilization	$_____
Orthodontic Expense	$_____
Oxygen Equipment	$_____
Pain relievers	$_____
Prescriptions	$_____
Psychiatric Therapy, Psychological Treatments	$_____
Routine Physicals	$_____
Special education for Deaf and Blind	$_____
Substance Abuse Rehabilitation	$_____
Support for corrective devices (i.e. Orthopedic shoes)	$_____
Transportation to receive health care ($.18 per mile)	$_____
Tuition for special school for handicapped	$_____
Vision Care (contact lenses, eyeglasses, etc.)	$_____
Other_____	
_____	$_____
TOTAL*	$_____

*Determine the portion you want withheld. Divide that amount by your number of pay periods and enter on the FLEXIBLE BENEFIT Enrollment Form under Health Care Flexible Spending Account.

**Insurance premiums are not eligible medical related expenses.