

**FLEXIBLE BENEFITS WORKSHEET**

**Instructions:** To estimate your potential unreimbursed health care and dependent care expenses for the coming year, be sure to review your "Explanation of Benefits" forms, tax receipts, expense vouchers, checkbook registry, etc., for the prior two years. Using these figures as a benchmark, conservatively estimate the amount of expenses you will most likely incur in the coming year in sections A & B below.

**A) Medical, Dental, Vision Expenses** (estimated unreimbursed annual health care expenses):

<b>MEDICAL</b>	<b>(Annual)</b>	<b>DENTAL</b>	<b>(Annual)</b>
Doctor Office Co-pays	\$ _____	Filings	\$ _____
Deductibles	_____	Bridges	_____
Routine OB-GYN Exam	_____	Crowns	_____
Physicals (school physicals, etc...)	_____	Dentures	_____
Co-Insurance	_____	Orthodontia	_____
Prescription/OTC Drugs	_____	Oral Exams	_____
Wheelchair, Crutches, and Medical Appliances	_____	Cleanings/X-Rays	_____
Other (miscellaneous) Costs	_____		

<b>VISION</b>		<b>HEARING</b>	
Eye Exams	\$ _____	Exams	\$ _____
Eyeglass Lenses/Frames	_____	Hearing Aids	_____
Contact Lenses	_____		

**A) Total Annual Medical Expense** \$ \_\_\_\_\_

**B) Dependent Care** (estimated dependent care expenses required for you and your spouse to continue working): **(Annual)**

Child Care Center/Babysitting services	\$ _____
Pre-school/Nursery school tuition	\$ _____
After-school programs, Day Camp	\$ _____

**B) Total Annual Dependent Care Expense** \$ \_\_\_\_\_

**Total (A) + (B) = total annual election of \$ \_\_\_\_\_ divided by payroll cycle = \$ \_\_\_\_\_ / pay period**

*If you are unsure if an expense is eligible for reimbursement , please call the IMS Flex department at (919) 877-9933.*