

**Flexible Spending
Account Benefit
Analysis Worksheet**



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Please note: This is not an enrollment form. Use this form to calculate the estimated amount you'll allocate on your enrollment form.

SECTION A: UNREIMBURSED HEALTH-RELATED EXPENSES

Estimated unreimbursed medical costs per year for you and your family:

Health insurance deductibles	\$ _____
Co-Insurance or Copays	\$ _____
Vision care (eye exams, contacts, eye glasses, etc.)	\$ _____
Routine exams (OB-GYN, physicals, etc.)	\$ _____
Travel costs related to medical care	\$ _____
Over-the-counter medications	\$ _____
Prescription drugs (including birth control)	\$ _____
Wheelchairs, crutches, medical appliances, etc.	\$ _____
Dental expenses (i.e. examinations, orthodontia, etc.)	\$ _____
Annual Total	\$ _____

SECTION B: DEPENDENT CARE EXPENSES

How much do you pay for dependent childcare or eldercare while you and your spouse work, look for work, or attend school?

Monthly	\$ _____
Annual Total	\$ _____

SECTION C: TOTAL EXPENSES

Add the annual totals from each section above to determine the amount to allocate to your FSA and/or HRA.

Section A total	\$ _____
Section B total	\$ _____
Grand Total	\$ _____
Divide total by number of pay periods: _____	= \$ _____