

REIMBURSEMENT ACCOUNT WORK SHEET

Instructions: Complete this work sheet to assist you in determining the amount to contribute to your Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Only expenses that you feel certain that you will incur during the next year . **Be conservative.** Remember that unused account balances at the end of the year must be forfeited. Use annual amounts.

Health Care Reimbursement Account Expenses

Medical Care

Deductibles, co-payments and out of pocket expenses not covered by your group health plan. Out of pocket expenses might include costs for well-baby care, routine exams, immunizations, prescription drugs including birth control pills, orthopedic shoes, etc.

Family Member
Expenses

You \$ _____
Spouse \$ _____
1 \$ _____
2 \$ _____
3 \$ _____ \$ _____

Dental Care

Deductibles, copayments and out-of-pocket expenses not covered by your dental plan. Include expected uncovered dental expenses for exams, x-rays, fillings, dentures, orthodontia, bridges, root canals, etc.

You \$ _____
Spouse \$ _____
1 \$ _____
2 \$ _____
3 \$ _____ \$ _____

Vision Care

Include expected uncovered expenses for exams, prescription eyeglasses, contact lenses, contact solutions, prescription sunglasses, etc.

You \$ _____
Spouse \$ _____
1 \$ _____
2 \$ _____
3 \$ _____ \$ _____

Hearing Care

Include expected uncovered expenses for hearing exams, hearing aids, hearing aid batteries, etc.

You \$ _____
Spouse \$ _____
1 \$ _____
2 \$ _____
3 \$ _____ \$ _____

Total Annual Estimated Health Care Expenses \$ _____

Divide by 12

This is your estimated per pay Health Care Reimbursement Account contribution:

Dependent Care Reimbursement Account Expenses

A baby sitter in the home while you are working \$ _____

Expenses for a day care center \$ _____

Expenses for nursery school \$ _____

Total Annual Estimated Dependent Care Expenses \$ _____

Divide by 12

This is your estimated per pay Dependent Care Reimbursement Account contribution: