

Flexible Spending Account Employee Tax Savings Worksheet

Include eligible expenses for you, your spouse, and your dependent(s)

1. Non-Reimbursed Medical Expenses

Estimated Family annual medical/dental/vision expenses – not covered by insurance:

Deductibles, coinsurance, copays	\$ _____
Hearing Expenses	\$ _____
Medical Equipment/Repair	\$ _____
Physical Exams	\$ _____
Prescription drugs	\$ _____
Chiropractic Care	\$ _____
Dental, including orthodontia	\$ _____
Vision, exams and hardware	\$ _____
Diabetic Supplies	\$ _____
Other Expenses	\$ _____
Total Annual Out-of-Pocket	\$ _____

2. Dependent Care (Daycare) Expenses

Weekly expense	\$ _____
Total Annual Daycare Expenses	\$ _____

3. Flexible Benefits Plan

Totals from 1 & 2 above	\$ _____
Multiply by estimated Tax savings of 28%	X28%
Your estimated Annual Tax Savings	\$ _____