

This worksheet can help you estimate your Health Care and Dependent Care expenses that would determine your annual election for the upcoming plan year.

## For Health Care FSA

### Health Care Expenses (Estimate)

Medical, pharmacy, dental and vision plan deductibles	\$ _____
Amount not paid or covered by insurance (co-pays or co-insurance)	\$ _____
Allowable over-the-counter medicine	\$ _____
Dental care	\$ _____
Vision care (glasses, contacts, solution, exams, etc.)	\$ _____
Orthodontia expenses - Special handling applies, please contact ProView prior to making your election.	\$ _____
Hearing (hearing aids)	\$ _____

**Other eligible HEALTH CARE expenses:**

_____	\$ _____
_____	\$ _____
_____	\$ _____

**Total Estimated Expenses** \$ \_\_\_\_\_

(Divide total expenses by the number of pay periods remaining in the year)

**Salary Reduction  
Per Pay Period**

\$ \_\_\_\_\_

## For Dependent Care FSA

### Dependent Care Expenses (Estimate)

Day care center (child up to age 13)	\$ _____
In-home care (up to age 13 for children; special handling applies for elder care)	\$ _____
Nursery and pre-school tuition (up to age 5)	\$ _____
After-school care (up to age 13)	\$ _____
Au pair services (up to age 13)	\$ _____
Summer day camp (up to age 13)	\$ _____

**Other eligible DEPENDENT CARE expenses:**

_____	\$ _____
_____	\$ _____
_____	\$ _____

**Total Estimated Expenses** \$ \_\_\_\_\_

(Divide total expenses by the number of pay periods remaining in the year)

**Salary Reduction  
Per Pay Period**

\$ \_\_\_\_\_