HEALTH CARE WORKSHEET

This worksheet will help you estimate your family's annual expenses for the new Plan Year. Please remember to deduct what your insurance will pay on each item. Not all covered expenses are listed: this is a list of some of the most common expenses submitted. If you are not sure if an expense is eligible, please contact Customer Service via email at 125@sheakley.com.

NOTE TO HSA OWNERS: If you are the owner of a Health Savings Account, refer to the plan information to determine your FSA eligibility and eligible expenses. If you are eligible to participate in the Flexible Spending Account, please note that **only dental and vision expenses can be reimbursed.**

Medical Expenses	**Current year's expenses**	**Estimate for next year**
Deductible	$_____	$_____
Co-payments: Office	$_____	$_____
Prescriptions	$_____	$_____
*Over-the-counter items (*For medical treatment only)	$_____	$_____
Chiropractors	$_____	$_____
Hospital Care	$_____	$_____
Physical Therapy	$_____	$_____
Routine Physical	$_____	$_____
Well Baby Care	$_____	$_____
Psychiatric Care	$_____	$_____
Other	$_____	$_____
Vision Expenses		
Eye Glasses	$_____	$_____
Eye Exams	$_____	$_____
Contact Lens	$_____	$_____
Lasik/Vision Correction	$_____	$_____
Dental Expenses		
Dental Exams	$_____	$_____
Extractions	$_____	$_____
Fillings	$_____	$_____
Crowns	$_____	$_____
Bridges	$_____	$_____
Orthodontics	$_____	$_____
X-rays	$_____	$_____
Other	$_____	$_____

Total Estimated Expenses $_____

Number of paychecks in the plan year _____

Divide to show per paycheck pre-tax deduction: $_____

Check your numbers carefully and remember to be conservative. Any funds left in the account are forfeited. Only estimate expenses you know you or your dependents will have completed.