

Flexible Spending Account Worksheet

Dependent Care Expenses:	\$ _____	x	_____	=	_____
(Cost of dependent care for children under 13 years.)	Monthly Expense		# of Months		Annual Cost

Medical Expenses <small>(Estimate your <i>uninsured</i> medical costs or co-pays per year)</small>	Projected Expenses
Insurance Deductibles	\$
Insurance Co-payments	\$
Dental Deductibles	\$
Dental Expenses	\$
Vision Deductibles	\$
Vision Expenses	\$
Hearing Expenses	\$
Prescriptions	\$
Medically Required Equipment	\$
Chiropractic	\$
Orthodontic	\$
Counseling Services	\$
Other Medical Expenses (Lab fees, x-rays, tests, etc.)	\$
Total Annual Cost:	\$

Self-Insured Schools of California
P.O. Box 1808
Bakersfield, CA 93303-1808
(661) 636-4413