Flexible Spending Account (FSA) Reimbursement Worksheet

This worksheet is to help you calculate your estimated out-of-pocket expenses. You should take into consideration any known factors that could have an impact on these amounts before year-end. You cannot begin, suspend, increase, or decrease your contribution during the plan year unless your family status changes. FSA election changes must be made within thirty (30) calendar days of the qualifying event, i.e. birth of child, marriage, divorce, etc.

I. Healthcare Reimbursement Account

Estimated expenses not covered by your healthcare, dental, or vision plans may include but not be limited to:

Healthcare expenses, such as: $ _____

- Deductibles, co-payments, and co-insurance $ _____
- Routine physical exams $ _____
- Hearing exams, hearing aids, etc. $ _____
- Other eligible expenses* $ _____

Dental Expenses, such as:

- Restorative services, such as gold fillings, crowns, or fixed bridge work $ _____
- Treatments, i.e. orthodontics $ _____
- Routine exams, cleanings, and x-rays $ _____

Vision Expenses, such as:

- Eye exams $ _____
- Eyeglasses, contact lenses, etc. $ _____

TOTAL HEALTHCARE REIMBURSEMENT AMOUNT: $ _____

II. Dependent Care Reimbursement Account

You must be able to provide either an employer tax ID number or a Social Security number for the dependent care provider along with appropriate receipts.

Dependent care expenses, such as:

- Babysitting, only while employee is at work or school full-time $ _____
- After school programs, i.e. YMCA, latch-key program $ _____
- Pre-school and nursery school programs $ _____
- Summer day-camp (not overnight) $ _____
- Elderly care $ _____

TOTAL DEPENDENT CARE REIMBURSEMENT AMOUNT: $ _____

****A sample list of eligible and non-eligible expenses can be found on the back of this worksheet or in the Niagara County Flexible Spending Account Benefit Plan booklet.***