



**Employee Election Form
Flexible Spending Accounts**

Contact Information:
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Qualified Expense Worksheet

HEALTH CARE EXPENSE WORKSHEET (Includes Medical, Dental and Vision Expenses Not Covered by Insurance.)	
Co-Payments / Co-Insurance / Deductibles	\$
Routine Well Visits (annual physicals, check-ups, allergy shots)	\$
Dental Expenses (braces, exams, preventative, crowns, bridges, etc.)	\$
Vision Expenses (eye exams, glasses, prescription sunglasses, contacts and supplies, etc.)	\$
Hearing Expenses (exams, hearing aids, batteries)	\$
Annual Screenings (pap smear, mammogram, prostate screen, etc.)	\$
Birth Control Pills, Maintenance / Prescription Drugs / Certain Over-The-Counter Drugs	\$
Therapy / Treatments (physical therapy, chiropractic, psychiatric, speech, etc.)	\$
Other Medically Necessary Un-reimbursed Expenses (IRS Publication 502 section 213)	\$
Total anticipated health-related expenses for this Plan Year	\$
Divide total anticipated expenses by # of pay periods in this Plan Year	
Deduction Amount Per Pay Period	\$

DEPENDENT CARE EXPENSE WORKSHEET	
Total Day Care Expenses for:	
First Quarter (January – March)	\$
Second Quarter (April – June)	\$
Third Quarter (July – September)	\$
Fourth Quarter (October – December)	\$
Total Expenses for Dependent Care Services Provided Inside Your Home	\$
Other Qualified Dependent Care Expenses (IRS Publication 503)	\$
Total planned dependent care expenses for this Plan Year	\$
Divide total planned expenses by # of pay periods in this Plan Year	
Deduction Amount Per Pay Period	\$