PAYCHEX®

Flexible Spending Account Deduction Worksheet

This is not an enrollment form. This worksheet is intended to assist you with the enrollment process by helping you calculate your applicable expenses and how much money would be in an FSA deduction each pay period.

Note: Expenses incurred by or on behalf of a domestic partner and/or a domestic partner's child(ren) are not reimbursable.

Medical/Dental/Vision Reimbursement Account

Annual Medical Expenses, such as:

Deductibles and co-pays	$ _____
Routine physical exams	$ _____
Prescriptions	$ _____
Chiropractic care	$ _____
Other	$ _____

Annual Dental Expenses, such as:

Deductibles and co-pays	$ _____
Routine check-ups	$ _____
Orthodontia	$ _____
Other	$ _____

Annual Vision Care Expenses, such as:

Exams	$ _____
Eyeglasses	$ _____
Contact lenses, solutions, cleaners	$ _____
Other	$ _____

Total Estimated Medical/Dental/Vision Expenses

$ _____ (Annual Amount, cannot exceed company max.) ÷ _____ (# of Pay Periods*) = $ _____ (Per Pay Period)

Dependent Care Reimbursement Account

Annual Dependent Care Expenses:

Payment to a dependent care facility or individual	$ _____
Payment to other care providers	$ _____

Total Estimated Dependent Care Expenses

$ _____ (Annual Amount, cannot exceed $5,000 IRS max.) ÷ _____ (# of Pay Periods*) = $ _____ (Per Pay Period)

Total Per-Pay-Period Reduction

(Add total estimated medical/dental/vision expenses and total estimated dependent care expenses.)

$ _____ Total Per Pay Period

*Weekly, 52 pay periods • Biweekly, 26 pay periods • Semimonthly, 24 pay periods • Monthly, 12 pay periods