

Health Care and Dependent Care Expense Account Worksheet

Plan Year
January 1 to December 31

Section A: Dependent Care (DC) Expense Account

Dependent Care Expenses: (Daycare, home-care, or child-care bills)	\$ _____	x _____	= _____	
	Monthly Expense	# of Months	Est. Annual Amount - DC	

Section B: Health Care (HC) Expense Account

Health Care Expenses (Estimate your <i>uninsured</i> medical costs or co-pays per year.)	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.)	\$
Estimated Annual Amount – HC	\$

Please estimate expenses carefully so you do not put more money into the SISC Flex Plan than you will spend on eligible expenses during the plan year. Remember: Any unused amounts will be forfeited.

SISC Flex
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