FLEX MADE Easy
An AMERILIFE Company
BENEFITS

This worksheet will help you determine the dollar amount you will spend for medical expenses during the plan year. In order to maximize your savings, please include expenses for you, your spouse and any of your dependents in your calculation.

Medical Expenses not covered by Insurance — Annual Estimate

Deductibles, Co-pays, Coinsurance	$ _____
Physician Visits/Routine Exams	$ _____
Prescription Drugs	$ _____
Insulin/Syringes	$ _____
Chiropractic Treatments	$ _____
Over-the-Counter Drugs and Medicine	$ _____
Other: _____	$ _____
Subtotal Medical Expenses	**$** _____

Dental Expenses Not Covered by Insurance — Annual Estimate

Checkups/Cleanings	$ _____
Fillings	$ _____
Root Canals	$ _____
Crowns/Bridges/Dentures	$ _____
Oral Surgery	$ _____
Orthodontia	$ _____
Other: _____	$ _____
Subtotal Dental Expenses	**$** _____

Vision/Hearing Expenses Not Covered by Insurance — Annual Estimate

Exams	$ _____
Eyeglasses	$ _____
Prescription Sunglasses	$ _____
Contact Lenses & Cleaning Solutions	$ _____
Corrective Eye Surgery (LASIK, cataract etc.)	$ _____
Hearing Exams/Hearing Aids & Batteries	$ _____
Subtotal Vision Expenses	**$** _____

TOTAL MEDICAL EXPENSES $ _____