



Address:
2110 Clearlake Blvd, Suite 200
PO Box 7500
Champaign, IL 61826-7500

Phone:
217-531-9000
877-272-8880

Fax:
217-239-4499
800-295-2990

Web:
www.bpcinc.com

Health Flexible Spending Account Worksheet

For Employee Use – Do not return to the HR Department

Listed below are expenses you and your family may have that are not completely covered by insurance. Estimate your Health Related Expenses not paid by medical, dental or other insurance for the next twelve months.

Expenses	Annual Cost
Co-pays for Office Visits, Health insurance deductibles & co-insurance expenses	\$
Co-pays for Prescriptions	\$
Contraceptives (prescription and over-the-counter)	\$
Chiropractors	\$
Dental Care and/or Orthodontic Expenses: Braces, dentures, fillings, oral surgery, routine checkups	\$
Diagnostic Fees: Lab work, X-rays	\$
Hearing devices and batteries	\$
Lasik Eye Surgery	\$
Medical Equipment/Devices to treat or because of a health condition: Crutches, Diabetic Testing Supplies, Oxygen, Wheelchairs	\$
Medical Care and/or Equipment for disabled dependents	\$
Over-the-Counter Drugs to treat a health condition: Advil, Bandages, Claritin, Pepcid AC, Tylenol	\$
Physical Therapy	\$
Psychiatric Therapy	\$
Sterilization Surgery	\$
Transportation to Receive Healthcare (\$.24 per mile effective 1-1-09)	\$
Treatment for Drug and/or Alcohol Addictions	\$
Vision Care Expenses: Contacts, Eyeglasses, Eye Exams, Solutions for eye or contact care	\$
Other Medical Expenses	\$
	\$
Total Cost Estimate for Year	a \$
Total Number of Payroll Deductions for Plan Year	b
Estimated Flex Spending Deduction Per Pay Period Divide Line a by Line b	\$

For a comprehensive list of eligible health expenses visit your company's customized web page or BPC's website (www.bpcinc.com) and click on the "Eligible Health Care Expenses" link.

Note - Vitamins and dietary supplements are NOT eligible expenses unless recommended in writing by a medical practitioner to treat a specific health condition. A partial list of **ineligible** expenses includes cosmetic surgery or procedures – medical or dental (e.g. teeth bleaching), and personal hygiene products (e.g. deodorant, mouthwash, toothbrushes, toothpaste).



Address:
 2110 Clearlake Blvd, Suite 200
 PO Box 7500
 Champaign, IL 61826-7500

Phone:
 217-531-9000
 877-272-8880

Fax:
 217-239-4499
 800-295-2990

Web:
www.bpcinc.com

DEPENDENT CARE EXPENSES WORKSHEET

For Employee Use – Do not return to the HR Department

You may elect to contribute a portion of your pay into the Dependent Care Expenses Reimbursement Account to reimburse you for amounts you pay for dependent care to enable you to be employed. Check the type of expense you will have and enter the amount of that expense in the space provided.

Preschool	\$ /Month x 12 =	\$ /Plan Year
Day Care Center	\$ /Month x 12 =	\$ /Plan Year
Home Care of Your Child or other Dependent	\$ /Month x 12 =	\$ /Plan Year
TOTAL COST ESTIMATE FOR PLAN YEAR		\$
Enter Appropriate Amount **		\$

** Divide the estimated annual total by the number of pay periods you are paid during the plan year. Enter this amount on your enrollment form under Dependent Care Reimbursement Benefit.

Employees have a choice between participating in their employer's DCAP on a salary reduction basis or claiming a Dependent Care Tax Credit. An employee usually chooses the route that produces the greatest tax benefits. Participating in a DCAP on a salary reduction basis often produces the greatest tax benefits for an employee, but not always.

Determining the relative tax benefits requires understanding of DCAP, Dependent Care Tax Credit, Earned Income Credit (EIC) and Child Tax Credit rules. Participating in a DCAP on a salary reduction basis can influence EIC and Child Tax Credit. An employee must take into account the increase or decrease in EIC and Child Tax Credit tax benefits that result from choosing DCAP participation versus claiming the Dependent Care Tax Credit. Employees are advised to consult with their tax advisor with regard to this issue.