Fill This Out To Save

Worksheet: Estimated Unreimbursed Health Care Expenses

The following is a worksheet to assist you in identifying your health care expenses. This worksheet only identifies a few of the most common expenses. There are many more eligible expenses reimbursable under the plan. Please refer to your communication brochure for a more extensive list of eligible expenses.

Medical

Deductibles	$ _____
Coinsurance payments*	$ _____
Copayments (HMO)	$ _____
Office Visit Copays	$ _____
Well-baby care	$ _____
Physicals/Annual checkups	$ _____
Pap Smears	$ _____
Immunizations	$ _____
Prescription Drugs	$ _____
Contraceptives	$ _____
Insulin	$ _____
Laboratory tests	$ _____
Splints, supports, corrective devices	$ _____
Hearing devices	$ _____
Therapy treatments (medical reasons only)	$ _____
Other expenses	$ _____

Dental

Deductibles	$ _____
Coinsurance payments*	$ _____
Fillings/crowns/bridges	$ _____
X-Rays	$ _____
Cleaning	$ _____
Fluoride treatments	$ _____
Dentures	$ _____
Orthodontia**	$ _____

** Please see insert "What You Need To Know" regarding Orthodontia before entering your estimated cost here.

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Grand Rapids, MI 49503-2911

Vision

Deductibles	$ _____
Coinsurance payments*	$ _____
Examinations	$ _____
Lenses	$ _____
Frames	$ _____
Contact Lenses	$ _____
Contact Solution	$ _____

Over-the-Counter Items & Medications

Used to treat or alleviate an injury or illness: NOTE: New regulations require a physician's prescription for over-the-counter medications to qualify for reimbursement. Refer to the inside of the brochure for more information & restrictions. $ _____

Total Annual Unreimbursed Health Care Expenses; Transfer this Total to Part B of the Enrollment Form

Cannot exceed your plan maximum as noted on the other side of this form. $ _____

Estimated Dependent Day Care Expenses

(when you *and* your spouse work)

Child care/Day care centers	$ _____
Child care in home	$ _____
After-school care	$ _____
Care of other dependents	$ _____

Total Annual Dependent Day Care Expenses (Cannot exceed $5,000 per calendar year or earned income of employee or spouse, whichever is less.)

Transfer this total to Part C of Enrollment Form $ _____

* Please keep in mind that any coordination of benefits with another group plan will reduce your out-of-pocket expenses.

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