CONFIDENTIAL EMPLOYEE WORK SHEET

Company Name _____ Dept._____

Name: _____ SSN: _____

Date of Birth: _____ Sex: _____ State of Residence:_____

NOTE: Items 1-3 must be shown per pay period; Item 4 is per year

1. From your paycheck, how much do you have deducted for:
   - A. Group medical coverage?.....$_____
   - B. Group term life insurance?.....$_____
   - C. Group disability insurance?.....$_____
   - D. Group dental insurance?.....$_____
   - E. Cancer, intensive care, accident or hospital indemnity coverage?.....$_____

2. If you are a single parent or your spouse works, how much do you pay for child care?..$_____

3. How much do you pay for dependent care for children 15 or older, for parents, etc? .....$_____

Total dependent care expenses (line 2 + line 3).....$ _____

4. Estimate your uninsured medical and dental costs per year:
   - A. MEDICAL
     1. Health insurance deductibles.....$_____
     2. Co-insurance .....$_____
     3. Vision care (eye exams, contacts, eyeglasses).....$_____
     4. Routine exams (OB/GYN, school physicals, etc).....$_____
     5. Travel costs related to medical care.....$_____
     6. Prescription birth control .....$_____
     7. Medically required health clubs and equipment .....$_____
     8. Cosmetic surgery.....$_____
     9. Wheelchair, crutches, medical appliances .....$_____
     10. Other.....$_____
   - B. DENTAL
     1. Dental examinations and cleanings.....$_____
     2. Braces and retainers .....$_____
     3. Fillings, crowns and bridges .....$_____
     4. Dentures, including replacements.....$_____
     5. Implants, inlays, X-rays .....$_____
     6. Fluoride Treatments .....$_____
     7. Other.....$_____

Total out-of-pocket expenses (medical & dental) ....$_____

_____ _____

Date Employee's Signature