NAME:

SCHEDULE A
MEDICAL EXPENSES

MEDICAL & DENTAL	
MEDICAL INSURANCE	
PRESCRIPTIONS	
CO-PAYMENTS	
NON-COVERED DOCTOR VISITS:	
DENTAL (Including Orthodonture)	
EYE CARE (Glasses - Contacts - Exams)	
CHIROPRACTOR	
PRIMARY CARE PHYSICIAN	
EMERGENCY ROOM	
LABORATORY EXAMS & FEES	
ORTHOPEDIC SHOES/BRACES	
OTHER:	
MILEAGE DRIVEN TO & FROM DOCTOR APPOINTMENTS	