WA State SEBB School Employment Transfer Form
Navia Benefit Solutions

If you enroll in the Medical Flexible Spending Arrangement (FSA) and/or Dependent Care Assistance Program (DCAP) and later change jobs to work at another Washington State school district, educational service district, or charter school, your enrollment may continue if your new position is eligible for participation in the School Employees Benefits Board (SEBB) Program Medical FSA and DCAP. To be eligible to transfer your Medical FSA and/or DCAP benefit, the lapse between employments must be 30 days or less and within the same plan year, and the hours you are anticipated to work cannot have changed.

Complete and submit this form to your new payroll or benefits office **no later than 31 days** after the first day of work. Your payroll or benefits office must submit your form to Navia Benefit Solutions for processing. Your per-paycheck deductions will increase, if necessary, to meet the annual contribution amount(s) by the end of the plan year.

Note: An employment transfer is not a qualifying event to change your Medical FSA and/or DCAP election amount(s).

Employee Information

Name (Last, First, Middle initial):	SSN:		
Street Address:	City:	State:	ZIP Code:
Daytime Phone:	Home Phone:		
Date of Birth:	Email Address:		

Election Amount(s) Information

Medical FSA Transfer			**Payroll or benefits office use**
Current Salary Contribution Amount (Annual election amount must remain the same as it was with your previous employer)	**Per Pay Period** $_____	**Annual Election** $_____	**# of Paychecks Remaining** _____
DCAP Transfer			
Current Salary Contribution Amount (Annual election amount must remain the same as it was with your previous employer)	**Per Pay Period** $_____	**Annual Election** $_____	**# of Paychecks Remaining** _____

I acknowledge that the information included on this form is true to the best of my knowledge, and that by submitting this form I authorize my new payroll or benefits office to continue payroll deductions for my Medical FSA and/or DCAP election amount(s).

Employee Signature_____Date_____

Employer Signature_____Date_____

Employer Contact Phone _____ Employer Contact Email _____

Employer Information ***(to be completed by the new employer's payroll or benefits office)***
After reviewing the employee's information and setting up the payroll deductions, sign and submit this form to Navia Benefit Solutions by fax: 425-233-6366, email: election@naviabenefits.com, or mail: PO Box 53250, Bellevue, WA 98015. For assistance, call 1-800-669-3539.

Previous Employer Name:	**Employment End Date:**	**Payroll or Benefits Office Use Confirmed Enrollment**		
Current Employer Name:	**Employment Start Date:**	☐ **Yes, enrolled**	**New Medical FSA Paycheck Contribution** $	**New DCAP Paycheck Contribution** $
Current Employer Code (Sub-agency):				