WA State PEBB Agency Transfer Form

If you enroll in the Medical Flexible Spending Arrangement (FSA) Limited Purpose FSA, or Dependent Care Assistance Program (DCAP), then later change jobs to work at another Washington State agency, higher-education institution, or community and technical college, your enrollment may continue. To be eligible to transfer your benefit, your new position must be eligible for these benefits through the Public Employees Benefits Board (PEBB) Program, and the gap between employments must be 30 days or less and within the same plan year.

Submit this form to your new agency's payroll or benefits office **no later than 31 days** after the first day of work with your new agency. (**Exception:** If your new employer is the University of Washington or Washington State University, you must submit the agency transfer request through Workday.) Your
per-paycheck deductions will increase, if necessary, to meet the annual contribution amounts by the end of the year. You cannot change your election due to a transfer.

Employee Information

Name (Last, First, Middle initial):	SSN (or Employee ID if higher education):		
Street Address:	City:	State:	ZIP/postal code:
Daytime Phone:	Home Phone:		
Date of Birth:	Email Address:		

Election Amount(s)

Medical FSA Transfer			**Payroll or Benefits Office Use**
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous agency*	**Per Pay Period** $_____	**Annual Election** $_____	**# of Paychecks Remaining** _____
Limited Purpose FSA Transfer			
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous agency*	**Per Pay Period** $_____	**Annual Election** $_____	**# of Paychecks Remaining** _____
DCAP Transfer			
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous agency*	**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 employer to continue payroll deductions for my Medical FSA, Limited Purpose FSA, or DCAP election amounts.

Employee Signature_____Date_____

Employer Signature_____Date_____

Employer Phone _____ Employer Email _____

Employer Information ***(to be completed by the new agency'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 help, call 425-452-3488.

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