WA State PEBB
Medical FSA or Limited Purpose FSA Termination Form

If you retire or end employment during the plan year, submit this form to your payroll or benefits office **within 30 calendar days** of your Public Employees Benefits Board (PEBB) benefit end date. Exception: University of Washington and Washington State University employees must make changes online in Workday.

Employee Information

Last Name, First Name	SSN (or Employee ID if higher education)		Separation Date
Address	City	State	ZIP/Postal code
Email – *Update your personal email address upon leaving employment to continue receiving important communications about your benefits.*			DOB (MM/DD/YYYY)

Continuation Options

You may be eligible to continue participating in your Flexible Spending Arrangement (FSA). Carefully read the continuation options listed below and mark your choice in the table below. There are no continuation options available for the Dependent Care Assistance Program.

1) **Stop participation –** Your eligibility to participate in the Medical FSA or Limited Purpose FSA ends on your PEBB benefit end date, which is the last day of the calendar month in which you were employed. Your final paycheck may include FSA contributions. However, you may claim your full annual election only for expenses that occurred before your PEBB benefit end date. Remember to submit all claims to Navia Benefit Solutions no later than March 31 of the following year.

2) If you elect to continue participation in your FSA, you may do so through these options:

   a) **Accelerate contributions –** You may pay for your remaining contributions for the plan year out of your last paycheck. Under this option, you may continue participating in the Medical FSA or Limited Purpose FSA and incur expenses through **December 31**. All claims must be submitted to Navia Benefit Solutions by March 31 of the following year. This option may not be available with all employers. Check with your employer for details.

   b) **COBRA: Continue payments post-tax –** Participants who have claimed less than they have contributed to the Medical FSA or Limited Purpose FSA are eligible for this option. Navia Benefit Solutions will mail a COBRA election notice to the address on file; make sure to keep your address current.

      i) You may continue participation by making post-tax contribution payments directly to Navia Benefit Solutions for the rest of the plan year. If you choose this option, Navia must receive the Navia COBRA election form no later than 60 days from the date your PEBB health plan benefits ended, or from the postmark date on the COBRA election notice, whichever is later. The first contribution payment is due 45 days after the 60-day election period ends.

      ii) Participation will continue through December 31, or until you fail to make the monthly contribution on the predetermined payment date. If you fail to make a timely payment, you may submit claims only for expenses incurred through your last active month of paid participation.

Debit card holders: Your debit card will be deactivated on the last day of the month in which you were employed. After that, you may submit claims for reimbursement.

Please choose one of the following and return to this form your payroll or benefits office.

❑ **YES**, I elect to continue participation in an FSA. I will contribute using the following payment method: ❑ Accelerate contribution on my last paycheck (if available through my employer). ❑ COBRA post-tax payment.	❑ **NO**, I decline to continue participation in an FSA and have access to my full election after termination.
Employee's Signature **X**	Date:

This form continued on next page

To be completed by payroll or benefits office

Employer: After reading the previous page and determining the benefit end date, fill out the information below and sign the form. Submit this form to Navia Benefit Solutions by fax: 425-233-6366 or toll-free fax 866-535-9227, email: election@naviabenefits.com, or mail: PO Box 53250, Bellevue, WA 98015. For help, call 425-452-3488.

Sub-agency or higher-education institution name and code:	Employee's Benefit Termination Date *(Last day of benefit-eligible month)*:
Employer Contact Email:	Employer Contact Phone:

If accelerated contribution is selected:

_____ - _____ = _____

Annual Amount Elected | Amount already contributed | Final Contribution from last paycheck

Employer's Signature **X** Date: