School Employee Benefits Board (SEBB)
FLEXIBLE SPENDING ARRANGEMENT (FSA) & DCAP CLAIM FORM

navia benefit solutions

FOR PLAN YEAR JANUARY 1, 2026 through DECEMBER 31, 2026
Submit all 2026 FSA, Limited Purpose FSA, and DCAP claims to Navia Benefit Solutions by March 31, 2027

Instructions

1. Use this form only for services that occur during the year shown above. **Do not use this form for debit card transactions**.
2. **Do not staple any documentation to claim form.** Please tape to separate sheet or include loosely in envelope. **Do not send originals** All claims are stored electronically and paper copies will be shredded.
3. Complete Section II for DCAP claims – Attach day care claim documentation showing the dates of service, type of service, cost of service, dependent's name, and provider's name and tax ID or Social Security number (no cancelled checks, balance forwards, or bank card receipts).
4. Complete Section III for FSA or Limited Purpose FSA claims. Provide claims documentation showing the dates of service, types of service, and cost (no cancelled checks, balance forwards, or bank card receipts). Itemize all expenses to prevent delays in reimbursement.
5. Sign the claim form. Fax, email, or mail your signed form using the contact information below. You can go to sebb.naviabenefits.com to view the status of your claim. Please allow at least 2 full business days for Navia to process your claim.

Section I – Employee Information

Last Name, First Name MI Daytime Phone Address City State ZIP/Postal Code ☐ **Address Change**	SSN Email - See information in Section IV

Section II – DCAP Claims **NOTE:** Claims for future services will not be accepted.

Start Date	End Date	Provider's Name, Address, Tax ID or SSN	Name of Dependent	Age	Cost for care period
Provider's Signature and Date					
See IRC Section 129 for qualifying day care expenses or consult your tax advisor for more information.			**Total Request $**		

Section III – FSA or Limited Purpose FSA Claims

Service Dates	Type of Service (Give general description)	Name of Provider	Self/Dependent	Net Cost	Is this replacing a previous ineligible debit card charge? (Y/N)
Did you use your debit card for any of these expenses? ❑ **No** ❑ **Yes**					
See IRC Section 213 for qualifying Health Care expenses or consult a tax advisor for more information.			**Total Reimbursement Request $**		

Section IV – Signature

To the best of my knowledge, my statements on this claim form are complete and true. I understand it is my responsibility to ensure this claim from my FSA, Limited Purpose FSA, or DCAP account and all information related to this claim is complete, accurate, and truthful. I understand I may be liable for the payment of all related taxes including federal income tax for an ineligible expense paid from the account. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. Any health care reimbursement claims are for eligible medical care expenses incurred by myself, spouse, or dependents during the plan year shown above. I certify that these expenses have not been reimbursed under this plan or by any other source, and that they will not be reimbursed by any other source or insurance. By providing an email address, I agree to receive all communications about this benefit via email. I may withdraw consent at any time without charge by contacting Navia Benefit Solutions by phone, email, or mail. I authorize my Medical FSA, Limited Purpose FSA, or DCAP account to be reduced by the amounts shown above.

Participant's Signature	Date

Forms and supporting documentation can be faxed, emailed, or mailed to: (425) 451-7002 or toll-free (866) 535-9227, claims@naviabenefits.com or Navia Benefit Solutions PO Box 5179 Fresno, CA 93755

Customer Service: (425) 452-3500 or (800) 669-3539; visit our website at sebb.naviabenefits.com