

WA State SEBB School Employment Transfer Form



If you enroll in the Flexible Spending Arrangement (FSA), Limited Purpose FSA, 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 at the same election amount for the remainder of the year. To be eligible to transfer your benefit, your new position must be eligible for these benefits through the School Employees Benefits Board (SEBB) Program, and the gap between employments must be 30 days or less and within the same plan year. The hours you are anticipated to work cannot have changed.

Submit this form to your new payroll or benefits office **no later than 31 days** after the first day of work. 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:		
Street Address:	City:	State:	ZIP/postal code:
Daytime Phone:	Home Phone:		
Date of Birth:	Email Address:		

Election Amounts

FSA Transfer			Payroll or benefits office use
Current Salary Contribution Amount <i>Annual election must stay the same as it was with your previous employer</i> <input type="checkbox"/> I confirm that neither myself nor my spouse are contributing to an HSA in the current tax year.	Per Pay Period \$ _____	Annual Election \$ _____	# of Paychecks Remaining _____
Limited Purpose FSA Transfer			
Current Salary Contribution Amount <i>Annual election must stay the same as it was with your previous employer</i>	Per Pay Period \$ _____	Annual Election \$ _____	# of Paychecks Remaining _____
DCAP Transfer			
Current Salary Contribution Amount <i>Annual election must stay the same as it was with your previous employer</i>	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 FSA, Limited Purpose FSA, or DCAP election amounts.

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 uploading it to the Navia Employer Portal at sebb.naviabenefits.com . For help, call 425-452-3488.				
Previous Employer Name:	Employment End Date:	Payroll or Benefits Office Use - Confirmed Enrollment <input type="checkbox"/> Yes, enrolled		
Current Employer Name:	Employment Start Date:	New Medical FSA Paycheck Contribution	New Limited Purpose FSA Paycheck Contribution	New DCAP Paycheck Contribution
		\$ _____	\$ _____	\$ _____
Current Employer Code (SEBB organization):				