School Employee Benefits Board (SEBB) School Transfer Form

If you enrolled in the Flexible Spending Arrangement (FSA), Limited Purpose 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, you can continue your enrollment at the same election amount for the rest of the plan year (January 1 through December 31). To be eligible to transfer these benefits, your new position must be eligible for them 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 may increase to meet the annual contribution amounts by the end of the year. If you had a gap in employment, your per-paycheck deductions may increase to meet the annual contribution amount by the end of the plan 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 Amount(s)

FSA Transfer		**Payroll or Benefits Office Use**	
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous employer.* ☐ I confirm that neither myself nor my spouse are contributing to an HSA in the current tax year.	**Annual Election** $_____	**Per Pay Period** $_____	**# of Paychecks Remaining** _____
Limited Purpose FSA Transfer			
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous agency.*	**Annual Election** $_____	**Per Pay Period** $_____	**# of Paychecks Remaining** _____
DCAP Transfer			
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous agency.*	**Annual Election** $_____	**Per Pay Period** $_____	**# 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 benefits office to continue payroll deductions for my FSA, Limited Purpose FSA, or DCAP election amounts as applicable.

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 employees' 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:	Confirmed Enrollment
Current Employer Name:	Employment Start Date:	Current Agency Code (Sub-agency):