WA State SEBB School Employment Transfer Form

If you enroll in the Medical 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. To be eligible to transfer your benefit, your new position must 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

Medical FSA Transfer			**Payroll or benefits office use**
Current Salary Contribution Amount *Annual election must stay the same as it was with your previous employer*	**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 employer*	**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 employer*	**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 Medical 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** ☐ 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):				