WA State SEBB
Medical FSA and Limited Purpose FSA Termination Form

If you end employment during the year or retire, submit this form to your payroll or benefits office **within 30 calendar days** of your School Employees Benefits Board (SEBB) benefit end date.

Employee Information

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

Continuation Options

You may be eligible to continue participating in your Medical Flexible Spending Arrangement (FSA) or Limited Purpose 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 (DCAP).

1) **Stop participation –** Your eligibility to participate in the Medical FSA or Limited Purpose FSA ends on your SEBB 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 for expenses that occurred before your SEBB 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 the following options:
   a) **Accelerate contributions –** You may pay for your remaining contributions for the plan year out of your last paycheck. This accelerated amount is equal to the difference between your annual election amount and the contributions you've made to date. Under this option, you may continue participation 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 participating 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 a Navia COBRA election form no later than 60 days from the date your SEBB 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 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 reviewing 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 uploading it to the Navia Employer Portal at **sebb.naviabenefits.com**. For help, call 425-452-3488.	
Agency/Sub-agency 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: