

WA State PEBB Agency Transfer Form
Navia Benefit Solutions



If you enroll in the Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) and later change jobs to work at another Washington State agency, higher-education institution, or community and technical college, your enrollment may continue if your new position is eligible for participation in the Public Employees Benefits Board (PEBB) Program Medical FSA and DCAP. To be eligible to transfer your Medical FSA or DCAP benefit, the lapse between employments must be 30 days or less and within the same plan year.

Submit this form to your new agency's payroll or benefits office **no later than 31 days** after the first day of work with your new agency. Your employing agency must submit your form to Navia Benefit Solutions for processing. (**Exception:** If your new employing agency is the University of Washington, you must submit the agency transfer request through Workday.) Your per-paycheck deductions will increase, if necessary, to meet the annual contribution amounts by the end of the plan year.

Note: An agency transfer is not a qualifying event to change your Medical FSA or DCAP election amounts.

Employee Information

| | | | |
|-------------------------------------|--|---|-------------------------|
| Name (Last, First, Middle initial): | | SSN (or Employee ID if higher education): | |
| Street Address: | | City: | State: ZIP/postal code: |
| Daytime Phone: | | Home Phone: | |
| Date of Birth: | | Email Address: | |

Election Amount(s) Information

| Medical FSA Transfer | | | Payroll or Benefits Office Use |
|---|-----------------------------------|------------------------------------|--|
| Current Salary Contribution Amount <i>Annual election amount must remain the same as it was with your previous agency</i> | Per Pay Period \$ _____ | Annual Election \$ _____ | # of Paychecks Remaining _____ |
| DCAP Transfer | | | |
| Current Salary Contribution Amount <i>(Annual election amount must remain the same as it was with your previous agency)</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 employer to continue payroll deductions for my Medical FSA or DCAP election amounts.

Employee Signature _____ **Date** _____

Employer Signature _____ **Date** _____

Employer Contact Phone _____ **Employer Contact Email** _____

| | | | |
|--|-------------------------------|--|--|
| Agency Information (to be completed by the new agency'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 fax: 425-233-6366, email: election@naviabenefits.com , or mail: PO Box 53250, Bellevue, WA 98015. For assistance, call 1-800-669-3539. | | | |
| Previous Agency Name: | Employment End Date: | Payroll or Benefits Office Use Confirmed Enrollment | |
| Current Agency Name: | Employment Start Date: | <input type="checkbox"/> Yes, enrolled | New Medical FSA Paycheck Contribution \$ _____ |
| | | | New DCAP Paycheck Contribution \$ _____ |
| Current Agency Code (Sub-agency or higher-education institution code): | | | |