State of Washington
Navia Benefit Solutions Agency Transfer Form

If you enroll in the Medical Flexible Spending Arrangement (FSA) and/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 will continue if your new position is eligible for participation in the Public Employees Benefits Board Program Medical FSA and DCAP. To be eligible to transfer your Medical FSA and/or DCAP benefit, there must be no more than 30 days' lapse in employment.

Complete and submit this form to your new agency personnel, payroll, or benefits office **no later than 30 days** after the date you transfer, but before the end of the plan year. 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 amount(s) by the end of the plan year.

Note: An agency transfer is not a qualifying event to change your Medical FSA and/or DCAP election amount(s).

Employee Information

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

Election Amount(s) Information

Medical FSA Transfer			**Personnel, Payroll, or Benefits Office Use**
Current Salary Contribution Amount (Must be the same as it was with your previous agency)	**Per Pay Period** $_____	**Annual Election** $_____	**# of Paychecks Remaining** _____
DCAP Transfer			**Personnel, Payroll, or Benefits Office Use**
Current Salary Contribution Amount (Must be the same as it was with your previous agency)	**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 am authorizing my new employer to continue payroll deductions for my Medical FSA and/or DCAP election amount(s).

Employee Signature_____**Date**_____

Employer Signature_____**Date**_____

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

Agency Information ***(to be completed by the new agency personnel, 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:**	**Personnel, Payroll, or Benefits Office Use** **Confirmed Enrollment**		
Current Agency Name:	**Employment Start Date:**	☐ **Yes, enrolled**	**New Medical FSA Paycheck Contribution** $	**New DCAP Paycheck Contribution** $
Current Agency Code (Sub-agency or higher-education institution code):				