SECTION 125 FLEXIBLE BENEFIT PLAN
REQUEST FOR ADDITIONAL CAPROCK STAR CARD(S)

Employer Name:	Your Member ID or Social Security Number:
Employee Name:	Phone Number**
Mailing Address:	
City / State / Zip Code:	

Please complete the required dependent information for additional card(s):

Name	Last four (4) digits of his/her Social Security Number	Date of Birth	Relationship
			☐ Spouse ☐ Child ☐ Other: __________
			☐ Spouse ☐ Child ☐ Other: __________
			☐ Spouse ☐ Child ☐ Other: __________
			☐ Spouse ☐ Child ☐ Other: __________
			☐ Spouse ☐ Child ☐ Other: __________

**We may contact you to obtain the full Social Security Number of your Dependent by phone.

_______________________________________ Employee Signature

_______________________ Date

PLEASE RETURN FORM TO:

Caprock HealthPlans · Post Office Box 780159 · San Antonio, TX 78278
Phone (210) 348-7300 / (800) 840-3977
Fax (210) 442-4681
Email: reimbursement@caprockhp.com