



Authorization Agreement for Direct Deposit for Section 125 Flexible Spending Account Reimbursements

By completing this form you are authorizing Caprock HealthPlans to deposit your Section 125 Flexible Spending Account Reimbursements to the bank account listed below. Your first manual claim submission will be paid by check; however, all subsequent manual claims will be paid via Direct Deposit to your bank account based on the completion of this form. Please complete and return this form to our office. If you have any questions, please contact Caprock HealthPlans Ancillary Services via email at reimbursement@caprockhp.com

I hereby authorize Caprock HealthPlans to initiate deposit entries to the checking account indicated below and the Depository named below, hereinafter called DEPOSITORY.

Depository Name _____

Branch (If Applicable) _____

Name on Account _____

City / State _____

Bank Account Number: _____

Transit/ABA Routing Number for
Incoming ACH Transactions (9 Digits): _____

Type of Account: _____ Checking _____ Savings

This authority is to remain in full force and effect until Caprock HealthPlans and DEPOSITORY have received written notification from me of its termination, in such time and manner as to afford Caprock HealthPlans and DEPOSITORY reasonable time to act on it.

Printed Name _____

Employer/Group _____

Signature _____ Date _____

PLEASE RETURN FORM TO:

Caprock HealthPlans · Post Office Box 780548 · San Antonio, TX 78278
Phone (210) 348-7300 / (800) 840-3977
Email: reimbursement@caprockhp.com