Maternity Grant Request Form

Your patient is participating in The Heritage Group's Maternity Grant Program. If the employee or their spouse or dependent child is pregnant, the employee is eligible to receive Health Savings Account (HSA) funding to help cover the costs of prenatal care and delivery. Your signature on this form confirms that the patient listed in section 1 is pregnant as of today's date.

PHYSICIAN: Please complete Section 2 below and return to the patient.

Section 1: Participant information (to be completed by employee or eligible spouse/domestic partner)

Name (Please Print)		Date of Birth
Address	City	State/Zip
If you are the spouse, domestic partner, or dependent child of the employee, print the name of the employee.		
Signature		Today's Date

Section 2: Physician information (health care provider only)

Provider name (Please Print)	Provider Signature	Date
		Expected Delivery Date

Signature confirms that the person listed above is pregnant as of the date on this form.

Submit completed form to HR Shared Service prior to the delivery of the baby.

Mail
The Heritage Group
HR Shared Services
6510 Telecom Dr., Suite 180
Indianapolis, IN 46278

Fax
1-317-228-8424

Email
HRSS@thgrp.com
Subj: CONFIDENTIAL - Maternity Grant Form

Questions? Contact HR Shared Services Monday-Friday, 8am - 5pm, 1-800-303-0408