LEGACY SOCIETY MEMBERSHIP FORM

As an expression of my/our desire to contribute to the continuing work of Sarasota Memorial Healthcare Foundation in supporting and advancing health care in our community, I /we have included Sarasota Memorial Healthcare Foundation in my/our estate plan. I/we understand that this statement is non-binding and does not constitute a legal promise of any future contribution.

The contribution will be made by Will or revocable trust or similar testamentary document as follows:

- ☐ Estimated value of the cash or other gift is $________________________________
- ☐ The gift will be made as a percentage of my/our estate as our bequest gift _________%, the estimated current value of which is $_______________________
- ☐ I/we have included SARASOTA MEMORIAL HEALTHCARE FOUNDATION as a beneficiary or recipient of one or more assets, with the estimated values shown below:
  - ☐ Retirement plan(s): ____
  - ☐ Financial or investment account(s): ___________________________________
  - ☐ Life insurance: ____
  - ☐ Residence or real estate: ____
  - ☐ Other asset(s): ____

My/our bequest shall be considered an/a

- ☐ Unrestricted bequest
- ☐ Restricted bequest for this purpose: _________________________________

Name(s): ____

Address: ____

City: ___________________________________ State: ____________ Zip:_____________

Phone: _______________________ Email: ____

____

Signature(s) Date

____

Please print your name(s) as you prefer to be acknowledged where appropriate.

- ☐ I/we wish for this gift to remain anonymous. Please do not list my/our name.
- ☐ Date of birth _______________ (MM/DD/YYYY)
- ☐ Date of birth (Spouse/Significant Other) _______________ (MM/DD/YYYY)

Attorney or financial planning professional contact information:

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Please return: Sarasota Memorial Healthcare Foundation
1515 S. Osprey Ave., Suite B4, Sarasota, Florida 34239-2918
Phone (941) 917-1286