The Dr. F. H. McLeod Legacy Society

Membership Verification Form

The Dr. F. H. McLeod Legacy Society recognizes those individuals who have provided future support to McLeod Health through the generosity of their estate plans. In a tradition of providing a living record of the legacy of our friends and supporters, this society is established.

NAME ______________________________ **BIRTH DAY** ____________________

ADDRESS ______________________________ **PHONE** ____________________

CITY______ ______________________________ **STATE** _____**ZIP** ______________

PHONE__________________________ **E-MAIL** __________________________

MARITAL STATUS ______________________

NAME OF SPOUSE ______________________________**BIRTH DAY** ____________
(If applicable)
I/We have included McLeod Health Foundation in my/our estate plan in one or more of the following:

___ Will Designation
___ Living Trust
___ Life Insurance Policy
___ Gift of Property
___ Charitable Gift Annuity
___ Donor Designated Fund
___ Charitable Remainder Trust
___ Charitable Lead Trust
___Retirement Plan Beneficiary
___Life Insurance Beneficiary
___Tax sheltered Annuity (403b)
___ Other Method ___________

Estimated Gift Amount: ______________________

I/We would like to designate our gift to support:______________________________

May we publish your name(s) as a member of the Legacy Society? ___Yes ___No
Please consider publishing your name as it may encourage others to participate.

Please print your names(s) as you would want it to appear on the Legacy Society correspondence.
____

Name of your Estate Planning Advisor: ______________________________________

Signature(s): ________________________ ________________________

Date Completed: __________________

Please return completed form to:
Roxanna Tinsley, Development Officer
McLeod Health Foundation
P. O. Box 100551
Florence, SC 29502-0551
Phone: 843-777-2694 Fax: 843-777-5174