

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/ZIP _____

MARITAL STATUS _____

NAME OF SPOUSE (If applicable) _____

E-MAIL ADDRESS _____

PREFERRED METHOD OF CONTACT Phone Mail E-mail

I/We have included McLeod Health Foundation in my/our estate plan in one or more of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Will Designation | <input type="checkbox"/> Charitable Gift Annuity | <input type="checkbox"/> Retirement Plan Beneficiary |
| <input type="checkbox"/> Living Trust | <input type="checkbox"/> Donor Designated Fund | <input type="checkbox"/> IRA Account |
| <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Charitable Remainder Trust | <input type="checkbox"/> Tax sheltered Annuity (403b) |
| | <input type="checkbox"/> Charitable Lead Trust | <input type="checkbox"/> Retirement Plan, IRA, 401k |
| | | <input type="checkbox"/> Other Method _____ |

Estimated Gift Amount: _____

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.

Signature(s): _____

Date Completed: _____

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