Baxter Health Foundation Legacy Society

Membership Verification Form

The Baxter Health Foundation Legacy Society recognizes those individuals who have provided future support to the Foundation through the generosity of their estate plans.

NAME_____ BIRTHDAY_____

ADDRESS_____ PHONE_____

CITY_____ STATE_____ ZIP_____

PHONE_____ E-MAIL_____

MARITAL STATUS_____ ANNIVERSARY_____

NAME OF SPOUSE_____ PETS_____
(If applicable)

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

_____Will Designation	_____Charitable Gift Annuity
_____Living Trust	_____Donor Designated Fund
_____Life Insurance Policy	_____Charitable Remainder Trust
_____Gift of Property	_____Charitable Lead Trust
_____Retirement Plan Beneficiary	_____Tax Sheltered Annuity (403b)
_____Life Insurance Beneficiary	_____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 name(s) as you would want it to appear on the Legacy Society Correspondence.

_____

Name of your Estate Planning Advisor:_____

Signature(s): _____ _____ Date: _____

Please return completed form to:
Baxter Health Foundation
624 Hospital Drive Mountain Home, AR 72653