

LEGACY OF HOPE SOCIETY

Legacy of Hope Society Membership Form

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Date of Birth (His): _____ Date of Birth (Hers): _____

Name(s) for Recognition Purposes: _____

YES! I/we confirm that I/we have made a planned gift to the Florida Cancer Specialists Foundation.

Please check one of the following. Please use my/our name as it is listed above.

- I/we give my/our permission to the Florida Cancer Specialists Foundation to publicly recognize my/our membership in the Legacy of Hope Society online and in printed materials.
- I/we prefer to remain anonymous. Please do not list my/our name(s).

My/our planned gift is in the form of a:

- | | |
|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Bequest | <input type="checkbox"/> Living trust distribution |
| <input type="checkbox"/> Charitable remainder trust | <input type="checkbox"/> Charitable gift annuity |
| <input type="checkbox"/> Charitable lead trust | <input type="checkbox"/> Life insurance policy |
| <input type="checkbox"/> IRA/retirement plan | <input type="checkbox"/> Real estate |

Estimated value of gift (optional): _____

The gift is:

Unrestricted: _____ Restricted: _____

(To the purpose noted above)

Signature

Date

Signature

Date