MOUNTAINS COMMUNITY HOSPITAL
FOUNDATION
The Legacy Society

The Legacy Society Pledge Form

Confidential

Thank you for your interest in becoming a member of the Mountains Community Hospital Foundation's Legacy Society. By pledging this wonderful gift in your Living Trust or Will, you are creating your lasting legacy in our mountain community. Your plans will be followed exactly as you outline them and your instructions to us can be changed at any time with a simple phone call to the Foundation office.

Understanding your wishes for the gift is extremely important to us. Please help us understand your goals by answering these questions.

1. Please tell us more about the intended use or purpose of the gift.

   ☐ I/We intend to leave an unrestricted gift, enabling Mountains Community Hospital to use the gift to address the greatest need at the time the funds become available.

   ☐ I/We want to designate the gift for a specific program or purpose as follows:

   _____

   _____

2. My/Our gift to Mountains Community Hospital Foundation will be funded by one or a combination of the following:

   ☐ A gift in my will or trust.

   ☐ A percentage of an IRA or other qualified retirement plan.

   ☐ A beneficiary of a life insurance policy.

   ☐ A beneficiary of a charitable remainder trust.

   ☐ Other: _____

   Estimated value of gift:

   ☐ Specific Amount $ _____

   ☐ Percentage of my estate _____ % Estimated to be $ _____

   Is Mountains Community Hospital Foundation a ☐ primary or ☐ contingent beneficiary?

3. By providing the name and contact information of your executor/trustee, you will help ensure that your wishes for your gift are honored at the time your gift is received.

Executor/Trustee Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

4. It is especially helpful to have a copy of the portion of your Will, Trust or Beneficiary Designation form that pertains to your gift. In many cases, IRA and other plan administrators will not contact Mountains Community Hospital directly to inform us of your gift or to make a distribution of your assets after your lifetime. To ensure that we receive your intended gift, it is helpful for us to have this information on file.

☐ Please check this box if you are attaching documentation for our files.

5. Please provide the information requested below. ☐ Check here if this is a joint gift.

Signature _____ Date _____

Printed Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

SSN _____ Date of Birth _____

Signature _____ Date _____

Printed Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Email _____

SSN _____ Date of Birth _____

☐ Please check this box if you would like for your gift to be anonymous.

THANK YOU!

Please send the completed form to:

Mountains Community Hospital Foundation
PO Box 1493
Lake Arrowhead, CA 92352
Phone: (909) 436-3263
Fax: (909) 336-2419

If you have any questions in preparing your Will or Living Trust to include Mountains Community Hospital Foundation, please contact:

Barry Robinson
Chair, Planned Giving Committee
(909) 436-8075
barryrobinson.arhd@gmail.com

or

Kim McGuire
Director of Community Development
(909) 436-3263
kimberly.mcguire@mchcares.com