ESTATE INTENTION FORM – Columbia Memorial Health Foundation: Tax ID: 14-1761112

This is a confidential record.
In order to include you in the *Legacy Society,* please complete and sign this Estate Intention Form, which applies to your future gift of a bequest to Columbia Memorial Health Foundation for the benefit of Columbia Memorial Health through your Will or Trust.

Recognition

☐ I/We understand that listing this gift may be an incentive for others to give, and are willing to be publicly acknowledged. Please list the donor(s) as followed: _____

☐ I/We prefer not to be listed or acknowledged publicly.

Provisions

☐ The Will/Trust provides that _____% shall be bequeathed to Columbia Memorial Health Foundation for the benefit of Columbia Memorial Health through the estate. As of today's date (month/day/year) _____ the estimated value of this provision in the estate plan would be approximately $_____.

☐ The Will/Trust provides that an outright gift of: $ _____ shall be bequeathed to Columbia Memorial Health Foundation for the benefit of Columbia Memorial Health through the estate.

The Will/Trust was signed on (month/day/year): _____

☐ The Will/Trust indicates that the bequest through the estate is unrestricted.

☐ The Will/Trust directs Columbia Memorial Health to use the bequest for a specific purpose, which is as follows (please contact the Foundation office to make sure your gift can be used as intended):

_____

☐ The Will/Trust provides that certain items of real or personal property shall be bequeathed to Columbia Memorial Health Foundation for the benefit of Columbia Memorial Health through the estate. As of today's date (month/day/year) _____the estimated value of these items is approximately $_____. The items are as follows:

_____

_____

I understand that I am not making a legal or binding commitment upon my estate by submitting this Estate Intention Form. Further, Columbia Memorial Health Foundation should understand that the size of my future gift might be significantly different from the amount estimated above for the purposes of valuation. If for any reason in the future Columbia Memorial Health Foundation is no longer included in my estate plan, I will notify you so that you can update your records and remove me from the planned giving Legacy Society.

Please Print:

Donor Full Name(s):_____/_____

Address: _____City: _____ST: _____ Zip: _____

Tel. #:_(___)_____Email Address: _____

Signature(s):_____/_____ Date: _____

Please return this form to: Columbia Memorial Health Foundation, 71 Prospect Avenue, Hudson, NY 12534. If you have questions, please contact Barbara Klassen, Executive Director, at (518) 828-8362. Thank you for your generosity.