CONFIDENTIAL MEMBERSHIP FORM

The Jacquelyn Shirer Circle of Planned Gifts has been established as a way to honor and recognize those who have made a provision for a future gift to the Garrett County Memorial Hospital Foundation. You can specify how your gift will assist the hospital with its health care mission.

Please fill out this form and return it to Kathy Greaser, Foundation Director at Garrett County Memorial Hospital, 251 North Fourth Street, Oakland, MD 21550 to confirm your membership. The information you provide will be kept in the strictest confidence by the Jacquelyn Shirer Circle of Planned Gifts unless you notify us otherwise. *This information will provide the Hospital with valuable information for future planning purposes.*

Name(s)____ Date of Birth _________________________________

Spouse____ Date of Birth _________________________________

Address ____

Telephone ____ E-Mail _____________________________________

❑ **I/WE HAVE INCLUDED THE GARRETT COUNTY MEMORIAL HOSPITAL FOUNDATION IN MY/OUR WILL OR REVOCABLE TRUST:**

❑ A specific bequest of $___________

❑ A percentage bequest of _______% Estimated value: $_____________

❑ Other (describe i.e. endowment fund):_________________________________

❑ **I/WE HAVE MADE THE GARRETT COUNTY MEMORIAL HOSPITAL FOUNDATION THE BENEFICIARY OF:**

❑ A life insurance policy

Amount or percentage to the Garrett County Memorial Hospital Foundation

Jacquelyn Shirer Circle of Planned Gifts_____________________________

The Foundation is: ❑ Primary Beneficiary ❑ Secondary Beneficiary (check one)

❑ A Qualified Retirement Plan (IRA, 401k, 403b).

Foundation interest: __________% Current market value of plan $___________

The Foundation is: ❑ Primary Beneficiary ❑ Secondary Beneficiary (check one)

❑ **I/WE HAVE NAMED THE GARRETT COUNTY MEMORIAL HOSPITAL FOUNDATION IN AN IRREVOCABLE TRUST OF LIFE-INCOME ARRANGEMENT:**

❑ Charitable Remainder Trust Foundation interest: _________%

Market Value_________% Payout: $__________

❑ Charitable Lead Trust Foundation interest: _______% Payout: ___________

Terms of years: __________

❑ Other (describe):____

PURPOSE

My/our future gift is:

❑ Unrestricted

❑ Restricted to the following purpose or program (specify) _____________________

____

DOCUMENTATION

❑ YES, I /we will share a copy of the portion of the will that applies to the endowment fund or the trust agreement of Change of Beneficiary Form (401, 403b, IRAs, Insurance) in which the Foundation is named.

AUTHORIZATION FOR USE OF NAME

❑ I/we authorize The Garrett County Memorial Hospital Foundation to include my/our name(s) on the membership list of the Jacquelyn Shirer Circle of Planned Gifts and on public recognition devices. I/we understand that this authorization is limited to the use of my/our name(s) only, and that the type and amount of my/our gift to the Foundation will remain strictly confidential.

❑ I/we would like to receive more information regarding making a planned gift to the Garrett County Memorial Hospital Foundation.

❑ I prefer to remain an anonymous member of the Jacquelyn Shirer Circle of Planned Gifts.

Signature ____ Date _____________________________

Signature ____ Date _____________________________