# LEGACY CIRCLE

## LEGACY GIFT INTENTION FORM

This form is to help you provide information about your estate gift to Baystate Health Foundation. By sharing this information, you can help ensure your gift will be used in accordance with your wishes. We are honored to help carry on your legacy. Thank you.

Name(s): _____

Address: _____

City: _____ State: _____ Zip code: _____

Preferred Phone: _____ Email: _____

Birthdate(s): _____

**My/our gift benefiting Baystate Health Foundation (BHF) is:** (check all that apply)

❑ Will ❑ Life insurance policy naming BHF as beneficiary

❑ Trust ❑ Charitable Gift Annuity

❑ IRA or Retirement Account naming BHF as beneficiary _____

❑ Other

**How would you like Baystate Health Foundation to use your gift?**
(e.g., unrestricted; a particular hospital; a care specialty; education and training; research; etc.)

_____

**My/our gift is in honor of:** _____

**Relation to you:** _____

**Please complete reverse side as well. Thank you!**

If you are comfortable, please provide an estimate of the current value of your estate gift to Baystate Health Foundation. All information will be kept confidential. Your gift estimate does not bind you or your estate in any way.

**Amount as % or $ (optional):** _____

**Legacy Circle:** With this signed form, we welcome you into our Legacy Circle as a recognized or anonymous member, depending on your preference and without disclosure of any gift amount. Membership includes invites to unique gatherings, special mailings, and recognition.

❑ Yes, I would like to be listed as a member of the Baystate Health Foundation Legacy Circle.

**My/our name should be listed in recognition as:**

_____

❑ Yes, I would like to be a member but please keep my membership anonymous.

❑ No, please do not include me in the Baystate Health Foundation Legacy Circle.

_____

**Signature** **Date**

_____

**Signature** **Date**

This document does not bind you or your estate. By signing this form, you are simply acknowledging your current plans to benefit Baystate Health in the future and are giving us guidance as to your wishes. **Thank you!**

**Please return this form and direct any questions to:**

**Baystate Health Foundation**
Attn: Gift Planning
280 Chestnut Street
Springfield, MA 01199

**Kylie Johnson, CAP**
413-794-7789
Kylie.Johnson@BaystateHealth.org

**All information will be kept strictly confidential.**