

# Planned Gift Intention Form

Please complete the following so that we can properly recognize and acknowledge your planned gift to Atrium Health Foundation.



## PERSONAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Partner/Spouse's Name (if applicable) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Email(s): \_\_\_\_\_

## EVERGREEN SOCIETY

Please recognize me/us in Evergreen Society as:

\_\_\_\_\_

I/we wish to remain anonymous.

## PLANNED GIFT

Will       Living/Revocable Trust       Irrevocable Trust       Life Insurance

Designated Beneficiary of: \_\_\_\_\_

## DESCRIPTION

A specific amount: \$ \_\_\_\_\_       A gift of a specific asset \_\_\_\_\_

A percentage of the residuary of my estate, trust or retirement plan, \_\_\_\_\_ %

Please add any details you wish to share: \_\_\_\_\_

*All information provided will be kept in the strictest confidence and will be used for internal planning purposes only. We understand that you may need to use estimates rather than exact figures. Atrium Health Foundation acknowledges that the future value of the gift may be significantly different than the original value.*

## PURPOSE

This is an unrestricted gift.       This gift is designated for: \_\_\_\_\_

I/we understand the Planned Gift Intention Form is not legal or binding. If our planned gift should change, we will notify the Foundation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN TO:  
Atrium Health Foundation  
208 East Boulevard  
Charlotte, NC 28203  
Phone: 704-355-0844

