LOCKWOOD Legacy Society

- Confidential Membership Form -

Yes, I want to help provide quality health care through a legacy gift.

Name(s)

Address

City

State Zip

Phone

Email

Signature(s)

Date

Signature(s)

Date

Date(s) of Birth _____ / _____ / _____

Date(s) of Birth _____ / _____ / _____

(see other side)

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LOCKWOOD LEGACY SOCIETY

- ☐ I have named Edgerton Hospital Capital Foundation as a beneficiary in my will or trust.
  Optional: Approximate value
  $_____ or % of estate.

- ☐ I have named Edgerton Hospital Capital Foundation as a beneficiary in my life insurance policy.
  Optional: Approximate value
  $_____

- ☐ I have named Edgerton Hospital Capital Foundation as a beneficiary in my retirement plan.
  Optional: Approximate value
  $_____

- ☐ I authorize my name as shown below to appear on the Lockwood Legacy Society membership list and other recognition materials (i.e. annual report, donor display, etc.).

  _____
  Please print

- ☐ I wish to remain anonymous and do not want my name to appear on the Lockwood Legacy Society membership list or other recognition materials.

- ☐ Please send me more information on estate planning.

Edgerton Hospital Capital Foundation

OUR VISION, SECURING THE FUTURE.

Edgerton Hospital Capital Foundation
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