

Planned Gift Intention Form

Thank you for including Holy Cross Hospital, Inc. in your estate plans and becoming a member of our Legacy Society. Your generosity and commitment to our mission will help make a lasting difference in the lives of patients and families throughout our community.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Organization Name (If Applicable): _____

Address: _____

City, State, ZIP Code: _____

Telephone: _____ Email: _____

As an expression of my/our commitment to the mission of Holy Cross Health (HCH), I/we am/are pleased to inform HCH of my/our intention to help provide for the future of the hospital through one or more of the following:

- | | |
|---|---|
| ☐ Will or Trust | ☐ Charitable Lead Trust |
| ☐ Life Insurance Policy | ☐ Retirement Plan or Beneficiary Designation |
| ☐ Charitable Remainder Trust | ☐ Other Assets (please describe): _____ |
| ☐ Charitable Gift Annuity | |

☐ *Attached, please find supporting documentation (e.g., copy of the page or paragraph from my will or trust, bequest, beneficiary designation form for life insurance or retirement plan) that describes my gift provision.*

The current estimated value of my/our gift: \$ _____

My/Our gift is _____% of the asset indicated above. If a percentage is given, please provide the current estimated value of the percent in today's dollars: \$ _____

Providing an estimated value is optional but helps us better understand the impact of your generosity and the difference your planned gift may make for Holy Cross Health. For recognition purposes, this information is also helpful in ensuring your gift is acknowledged and recognized at the appropriate giving level.

My/Our planned gift is designated to:

- ☐ Unrestricted to provide flexibility for Holy Cross Hospital to pursue its mission.
- ☐ Restricted for the following priority (please consult with HCH if you are considering a restricted gift as we want to honor your intention): _____

Gift Type:

- ☐ Revocable – The gift may be changed or revoked during my/our lifetime.
- ☐ Irrevocable – The gift will not be changed or revoked, except as permitted by the terms of the gift agreement.

Gift Recognition

List my/our names as follows in all published lists: _____

☐ I/We prefer to be listed as anonymous in all published lists.

☐ I/We would like to discuss naming opportunities associated with our irrevocable gift.

☐ Gift in memory of / in honor of: _____

Additional Information (*optional*):

Signature _____ Date _____

Signature _____ Date _____

Attorney Name: _____

Telephone: _____ Email: _____

Executor Name: _____

Telephone: _____ Email: _____

All planned giving donors qualify for inclusion and recognition in Holy Cross Health's Giving Societies and Legacy Society. This is our way of thanking and recognizing you for your contributions to our mission.

Holy Cross Health does not provide legal or financial advice. We encourage you to consult your attorney, financial planner, or tax advisor when considering a planned gift.

Please return this completed form to:

Holy Cross Health Foundation
4725 North Federal Highway
Fort Lauderdale, FL 33308
Donations@Holy-Cross.com