Pledge of Support

FOR ALL OF US.

I/We make the following pledge in support of The MetroHealth Foundation:

Personal Information

Name _____

Spouse's Name_____

Address _____

City _____

State_____ Zip_____

Cell phone _____

Other phone
(please specify ☐ work ☐ home) _____

Email _____

☐ This is a joint gift

We will list your name in our publications unless you request otherwise below.

☐ I wish this gift to be anonymous. I understand that this gift will not be listed in any MetroHealth publications.

Gift Information

I/We make a pledge of $_____

I/We will give $_____ per year
for ____ years (max 5 yrs.)

Pledge payment will begin (month/year) _____

Please send reminders: ☐ quarterly ☐ semi-annually ☐ annually ☐ no reminders

I/We would like this gift to be:

☐ Unrestricted (used where the need is greatest)

☐ Applied to a department or area designated below
(Multiple designations – with amounts – may be listed below.)

_____

_____

_____

_____

Pledge Payment Options: *(Please indicate your choice below. Gifts may be spread over 5 years.)*

☐ Cash or Check enclosed for $_____ payable to The MetroHealth Foundation.

☐ Credit Card: Card number _____ CSC/CVV # on back:_____ Exp. date _____

Signature _____

Charge scheduled payments of $_____ in the following months:

☐ Jan. ☐ March ☐ May ☐ July ☐ Sept. ☐ Nov. ☐ Feb. ☐ April ☐ June ☐ Aug. ☐ Oct. ☐ Dec.

☐ **Electronic Funds Transfer (EFT):** Please send me the proper forms to authorize The MetroHealth Foundation to electronically conduct approved transactions directly with my financial institution(s). Request forms by calling 440-592-1387 or email cmeehan@metrohealth.org.

☐ **Stocks, Bonds, Mutual Funds or Other Property:** Approximate value: $_____
Please have a Foundation gift officer contact me.

☐ **Matching Gift:** In addition to my own personal gift commitment, _____ will match my gift.
I have enclosed the completed form.

☐ **Deferred Gift:** Please fill out the reverse side of this form.

TOTAL of this side and reverse side: $_____

Date:_____ Signature _____

Spouse's signature (if applicable)_____

The MetroHealth Foundation, Inc.
2500 MetroHealth Drive, Cleveland, OH 44109
Office: 216-778-5665 • metrohealth.org/foundation

MetroHealth

Future Support

Personal Information

Name _____

Spouse's Name_____

Address _____

City _____

State_____ Zip_____

Cell phone _____

Other phone
(please specify ☐ work ☐ home) _____

Email _____

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Gift Information

Gift type:

☐ Will Bequest
☐ Life Insurance
☐ Charitable Remainder Trust
☐ Revocable Living Trust
☐ Retirement Account
☐ Other_____

Date of birth _____

Does your gift benefit someone else (i.e., a spouse) before MetroHealth?

☐ Yes ☐ No

If so, does that person have a similar gift provision?

☐ Yes ☐ No

Date of birth of Survivor Beneficiary_____

While all deferred gifts are important, those contingent on the life of spouse or other beneficiary are counted only if the other person has made the same deferred gift commitment.

Exact Language of Provision

Write in the space below or attach a copy.

_____

_____

_____

Value of Provision

For percentages and remainders of an estate, provide a good faith estimate of the dollar value as of the date this form is signed.

_____

_____

_____

Areas of MetroHealth to be supported (if any)

_____

_____

_____

Date _____

Signature _____ Spouse's signature (if applicable)_____

We recognize that values of deferred gifts as well as the provisions themselves may change over time. Your signature verifies only that the above information is accurate as of this date and does not represent a binding commitment to MetroHealth. Should you ever update your gift plans, please contact us at mhfoundation@metrohealth.org.