**Please return completed form to:**

MCHS Foundation

1000 N Oak Ave, 1R1

Marshfield, WI 54449-5777

[giving@marshfieldclinic.org](mailto:giving@marshfieldclinic.org)

Phone: 715-387-9249/800-858-5220



# DOEGE LEGACY SOCIETY ENROLLMENT FORM

Because of my/our special regard for Marshfield Clinic Health System and its patient care, research and education mission and realizing the importance of planned gifts to the Clinic’s future, I/we have made the following provisions for Marshfield Clinic Health System Foundation in my/our estate plan(s):

1. **DESCRIPTION OF LEGACY GIFT:**

a gift of a specific amount

a gift of a specific item of property (please describe item):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

a percentage gift of the residue of my estate: \_\_\_\_\_\_\_%

My/our gift is in:

will

revocable trust

irrevocable trust

charitable trust

life insurance beneficiary designation

retirement plan beneficiary designation

bank account beneficiary designation

(CD, money market, etc.)

other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. **CURRENT VALUE OF LEGACY GIFT:**

The approximate current value of my/our gift is $ .

NOTE: Marshfield Clinic Health System Foundation uses this information to anticipate future gifts for budgeting and forecasting purposes. This is not a binding obligation to gift the stated amount to Marshfield Clinic Health System Foundation.

3. **USE OF LEGACY GIFT:**

My/our gift is to be used for the greatest need.

My/our gift is designated to be used for:

NOTE: If your gift is intended to create a named endowment, fund, program or space, please contact the Marshfield Clinic Health System Foundation for information regarding Marshfield Clinic Health System’s naming policies and practices.

4. **RECOGNITION FOR LEGACY GIFT:**

Please list my/our name(s) on the Doege Legacy Society donor wall and in published

Doege Legacy Society listings as:

I/we wish to remain anonymous during my/our lifetime(s), then my/our names should be

listed as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I/we wish to remain anonymous during my/our lifetime(s) and after the gift matures.

By signing this enrollment form, I/we affirm my/our commitment to Marshfield Clinic Health System Foundation. However, this enrollment form shall not be binding upon my/our estate, and the information contained herein shall be used for Marshfield Clinic Health System Foundation purposes only.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name Birthdate Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Name (if two donors) Birthdate Date Signed

*MCHS Foundation Staff Use*

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Received By Date Rec’d