Confidential
Legacy Gift Intention

MemorialCare
Saddleback Medical Center Foundation

LEGACY CIRCLE

We are honored that you have chosen to leave a legacy at MemorialCare Saddleback Medical Center and make a lasting impact for generations to come. This internal form allows us to confidentially record your intentions and ensure your wishes are honored in the future.

Donor Information

NAME	DOB
NAME	DOB
ADDRESS	CITY, STATE, ZIP
PHONE	EMAIL

Legacy Gift Intention & Purpose

Please describe your legacy gift:

- ❑ Will or Living Trust
- ❑ Charitable Remainder Trust or Charitable Lead Trust
- ❑ Other: _____

- ❑ Beneficiary of:
  - ○ Retirement Account
  - ○ Donor Advised Fund
  - ○ Life Insurance
  - ○ Bank or Investment Account

For planning purposes, the current estimated value of this gift is $_____

Please indicate your preferred designation for this gift:

- ❑ Area of Greatest Need
- ❑ Specific Area: _____

Special Notes (optional): _____

Recognition

Your legacy gift qualifies you as a member of Saddleback Medical Center Foundation's prestigious Legacy Circle, a special group of donors who have remembered the hospital in their estate plans. Please indicate your recognition preference.

- ❑ I/we wish to remain anonymous.
- ❑ My/our name should appear on materials and Legacy Circle plaque as follows:

_____

Signature(s)

Donor Signature: _____ Date:_____

Donor Signature: _____ Date:_____

If you feel comfortable, kindly provide a copy of the section of your will, trust, or beneficiary form that pertains to Saddleback Medical Center. Thank you for choosing to make an impact at Saddleback!

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