Marian Regional
Medical Center Foundation
A Dignity Health Member

Intent for a planned gift

As evidence of my/our desire to provide a legacy of support to Marian Regional Medical Center Foundation, I/we hereby inform you that I/we have made a provision for a gift in my/our estate plans.
I/we understand that this commitment can be changed or modified by me/us at any time.

It is my/our intent to leave a legacy gift to Marian Regional Medical Center Foundation through my/our:

☐ Will
☐ Living Trust
☐ IRA or Retirement Plans Assets
☐ Charitable Trust
☐ Life Insurance Policy
☐ Other Asset *(please explain below)*

_____

It is my/our intent to restrict my/our legacy gift to benefit the following area(s) at Marian Regional Medical Center Foundation, gifts with no restriction allow the organization to apply the gift toward the area of greatest need.

☐ Where the Need is Greatest
☐ Marian Cancer Care at Mission Hope Cancer Center
☐ Emergency & Trauma Services
☐ Home Health and Hospice
☐ Behavioral Health Services
☐ Sue J. Sword Heart Center
☐ Other: _____

For the benefit of Marian Regional Medical Center Foundation's long-term legacy gift planning purposes,

the estimated value of my/our gift as of this date is $ _____.

Donor Name: _____

Spouse Name: _____

Mailing Address: _____

City/State/Zip: _____

Primary Phone(s): _____

Email Address: _____

☐ I/we agree to have my/our name(s) published on Marian's Legacy Society donor wall, recognizing my/our planned gift in order to help motivate others to make a future gift to benefit the Marian Regional Medical Center Foundation.

I/we understand this permission is to share my/our name(s) only and not amounts, which will not be disclosed.

If the box above is checked, please list your name(s) as you would like it/them to appear in print:

_____

☐ Please do not list my/our names publicly.

Donor Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Marian Regional Medical Center Foundation • 1400 East Church Street, Santa Maria, CA 93454
(805) 739-3595 (office) • (805) 739-3599 (fax) • Federal Tax ID: 95-3818027

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If your gift is for a percentage of your estate, rather than a fixed amount, the Marian Foundation will be happy to use your good faith estimate of the current value based on this percentage. While ***not*** required, you may wish to include a copy of the relevant portion of related documents.

Though it is not necessary to provide, the following information may help our Board of Directors make determinations regarding Marian Regional Medical Center's financial future.

_____ **I have attached documentation from my will, retirement plan, life insurance policy, or trust.**

Please mail this completed form and any accompanying documentation to the address below:

Marian Foundation
Attn: Alisha Holley
1400 E. Church Street
Santa Maria CA 93454

Optional Estate Representative Contact Information:

Name: _____ Role/Relationship: _____

Primary Phone: _____ E-mail: _____

Marian Regional Medical Center Foundation • 1400 East Church Street, Santa Maria, CA 93454
Alisha Holley, MBA, CFRE • alisha.holley@dignityhealth.org
Office: (805) 739-3595 • Cell: (805) 448-6101