Kaweah Health Foundation's

Heritage Club

ENROLLMENT FORM

Date: _____

Name of member #1: _____
Address: _____
City: _____ State/Zip: _____
Home/Cell Phone: _____
Work Phone: _____
Birth Date: _____Email: _____

Name of member #2: _____
Address: _____
City: _____ State/Zip: _____
Home/Cell Phone: _____
Work Phone: _____
Birth Date: _____Email: _____

Heritage Club membership has a Minimum of $5,000 per person

☐ I/We have named KAWEAH HEALTH FOUNDATION as beneficiary of my ***trust/will*** for $_____

☐ I/We have named KAWEAH HEALTH FOUNDATION as beneficiary of my/our

investment account in the amount of $ _____

Name of Company: _____

Representative (if applicable): _____

Policy Number (if applicable): _____

Company Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

☐ I prefer to make my Heritage Club gift to the Endowment Fund now. Enclosed is my check made out to KAWEAH HEALTH FOUNDATION for $ _____

Thank you for joining the Heritage Club to support health care services offered at Kaweah Health. Please return this updated form to:

Email: Foundation@KaweahHealth.org
Mail: 216 S. Johnson Street Visalia, CA 93291
Phone: (559) 624-2359

Kaweah Health Foundation