Kaweah Delta Hospital Foundation | EVERY GIFT COUNTS

THE Heritage CLUB

I/WE HAVE TAKEN ONE OF THE FOLLOWING ACTIONS TO JOIN THE HERITAGE CLUB:

HERITAGE CLUB MEMBERSHIP HAS A MINIMUM OF $5,000 PER PERSON

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

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

life insurance policy/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 DELTA HOSPITAL FOUNDATION for $ _____

Enrollment Date: _____

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

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

For membership recognition please list my/our name(s) as follows:

_____

(SAMPLES: MARY JONES, MR. AND MRS. ROBERT JONES; MARY AND BOB JONES)

☐ I prefer my membership to be anonymous; please do not include my name in printed lists of members.

I/we would like to recieve a complimentary commemorative Heritage Club paperweight.

☐ Yes ☐ No thank you; please put the funds to good use for health care services.

The Heritage Club Membership committee member who invited me to join the Club is: _____

_____

THANK YOU FOR JOINING THE HERITAGE CLUB TO SUPPORT HEALTH CARE SERVICES OFFERED AT KAWEAH DELTA HOSPITAL. PLEASE RETURN THIS MEMBERSHIP ENROLLMENT FORM TO:

Email: foundation@kdhcd.org;
Mail: 216 S. Johnsons Street Visalia, CA 93291
Phone: (559) 624-2359