

# Legacy intention form

Please complete this form to document your non-binding estate gift to the Aflac Cancer and Blood Disorders Center of Children's Healthcare of Atlanta. Knowing your intentions helps us plan for the future as we continue to offer quality healthcare to children in the years to come.

Name(s): \_\_\_\_\_

Preferred address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Preferred phone number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Spouse's date of birth: \_\_\_\_\_

I have made the following provision(s) for the Aflac Cancer Center as follows:

- Outright bequest payable upon my/our death(s) directly to the Aflac Cancer Center
- Provision in will of surviving spouse payable to the Aflac Cancer Center at death
- Charitable remainder trust with the Aflac Cancer Center named as a charitable beneficiary
- Testamentary trust established at death, naming the Aflac Cancer Center as a charitable beneficiary
- Life insurance payable to the Aflac Cancer Center at death
- Beneficiary designee on an IRA, pension plan, 401(k), 403(b) or revocable living trust to the Aflac Cancer Center
- Other: \_\_\_\_\_

Today's value of my future gift provision to the Aflac Cancer and Blood Disorders Center of Children's Healthcare of Atlanta is approximately \$ \_\_\_\_\_. However, the Aflac Cancer Center and I both understand that future fluctuations/changes in the market/economy may have an impact on this current value.

- Please allocate my gift to the area of greatest need\*
- I wish my gift to support: \_\_\_\_\_

**\*Note:** Gifts allocated to the area of greatest need are the most powerful resources because of the ever-changing priorities and needs at Children's.

\_\_\_ I have enclosed a copy of the relevant section of my will or trust or a copy of my beneficiary form which will be held by the Children's Healthcare of Atlanta Foundation in strict confidence.


\_\_\_ My contribution may be noted in future Children's Healthcare of Atlanta publications.  
(No value will be printed or released without permission.)


Donor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Donor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for continuing the legacy and helping to secure the future of Children's for generations to come.

Please email, mail or fax Mary McCormack, Senior Director – Legacy Giving  
Children's Healthcare of Atlanta Foundation, Park North, 1577 Northeast Expressway, Atlanta, GA 30329

 404-785-9481

 404-785-7355

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