



Contribution Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Please find enclosed my tax-deductible gift of:

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$500 |
| <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$100 |
| <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$50 |
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> Other _____ |

- I wish this gift to be anonymous.
- This gift is: in honor of: in memory of:

Name: _____

Address: _____

- My company will match my gift. Company Name: _____
- I am interested in learning more about how to include Health Connected in my estate plans.
- Stay connected! Join our email list. You can unsubscribe at anytime.

Payment:

- Enclosed is my check made payable to **Health Connected**.
- Please charge my: Visa MasterCard

Card#: _____ Expiration Date: ____/____/____

CVC Code: _____ Billing Zip Code: _____

Signature: _____

Please return this form to:

Health Connected
P.O. Box 51984
East Palo Alto, CA 94303
650.367.4940 Fax

For questions, please contact executivedirector@health-connected.org.