



Please complete this form and return to:

47 Liberty Street South, Bowmanville, ON L1C 2N4 T: 905.623.3331 x 21881 E: bhfoundation@lh.ca

OUR HEALTH CARE PERSONAL INFORMATION					
	☐ Mr. ☐ Mrs.	□ Dr. □ M	Ir. & Mrs. Ms.		
First Name		Last Name		Spouse Name	
Organization (if app	olicable)				
Address					
City	Provinc	e	Postal Code .	Country	_
Phone (Day)		Phone (Alternate)		Email	
		FUN	ID DESIGNATION	N	
Where would you li ☐ Redevelopment		-	se indicate design	ation)	
This gift is in honou	ır of/in memory o	f/in celebration	of (person's name)	
Would you like us to If yes, please provid (If unable to provide	de <u>Complete Nam</u>	e & Address of N	lext of Kin/Honour	<u>ree</u>	
☐Mr. ☐Mrs. [□ Dr. □ Mr. & M	rs. 🔲 Ms.			
First Name Last Name					
Address					
City	Provi	nce	Postal Code	Country	_
Funeral Home				-	
		PA	YMENT METHOD		
☐ One-time Payme	ent 🗆 Monthly	Gift Amou	ınt \$	Preferred Process Date	
☐ Pledge Pledge Amount:	\$	_ Annual Pled	ge Payment: \$	Pledge Begins:	
Pledge Period:	☐ 3 years	☐ 5 years	☐ 10 years	Other	
Preferred Pledg	e Process Date		_		
Cardholder's Name			Card Type: □ VISA	☐ MasterCard ☐ American Express	
Card Number					
Expiry Date (mmyy)		Card Security	/ Code		
Further comments:					

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