HOPE LIVES HERE

Supporting Patients of Chase Brexton Health Care in Our Community

EMPLOYEE ENROLLMENT FORM

Thank you for joining Hope Lives Here. Your participation helps us build a healthier, stronger community for us all. This year, our focus is on creating a sustaining network of donors to help our patients in-need. Thank you for your reoccurring gift!

MEMBER INFORMATION

Please list your contact information as you would like it to appear in Hope Lives Here membership recognition.

Name _____

Department _____ Center Location _____

Signature _____ Date _____

GIFT LEVEL (PLEASE SELECT ONE)

❑ $50/pay check ❑ $25/pay check ❑ $5/pay check

❑ $2.50/pay check ❑ $1.25/pay check ❑ $0.25/pay check

❑ Other ($_____)*

Payment Option (please select one)

❑ Recurring; Deduct per paycheck ❑ One-time deduction

Would You Like to Direct Your Gift to a Specific Chase Brexton Center?
(please select only one)

❑ Baltimore City ❑ Columbia ❑ Easton ❑ Glen Burnie ❑ Randallstown

❑ Please direct my gift where it's needed most

I give because_____.

❑ Check here to opt out of Employee Giving emails.
❑ Check here to opt out of incentive gift benefit.

*Members who select "other" must contribute at least $5/year to qualify. Membership benefits will be based on the lower of the two giving levels they fall between.

If paying by check or credit card, please turn over to complete >

INSTRUCTIONS

Please return this completed form to Alexa Milanytch.

By Inter-Office Mail:
Attn: Alexa Milanytch
Development Dept.
Mt. Vernon Center
4th Floor

By Email:
Alexa Milanytch
amilanytch@chasebrexton.org

You can also enroll online at **HopeLivesHereMaryland.org.**

Questions?
410-837-2050 x1144

PLEASE RETURN THIS FORM BY NOVEMBER 21, 2019.

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EMPLOYEE ENROLLMENT FORM, CONTINUED

Payment

❑ Pay by check. Please make checks payable to Chase Brexton Health Care.

❑ Pay by credit card. Please fill out the following:

Credit Card Number _____

Expiration Date _____

Cardholder Name _____

Billing Address

_____

Billing City/State/Zip

_____

Credit Card Commitment (Please select one)

❑ $_____/month

❑ $_____ One time contribution

I authorize Chase Brexton Health Care to charge the indicated amount to my account.

Signature _____

Date _____