



## International Waldenstrom's Macroglobulinemia Foundation Member Services Fund Giving Form

First Name (please print) \_\_\_\_\_

Family Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip / Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Telephone \_\_\_\_\_ E-mail \_\_\_\_\_

Your Member Services Fund gift is very important for sustaining and expanding member services. We kindly ask you to consider the giving levels below. Tax receipts will be issued for all gift levels.

*(Note that all the following gifts will be used first to satisfy operating expenses and then will be considered by the Board of Trustees for other IWMF activities including research.)*

### IWMF Member Services Fund Giving Circles

#### Annual Gift amount

- |   |                      |
|---|----------------------|
| <input type="checkbox"/> \$1 - \$99       | WMer                 |
| <input type="checkbox"/> \$100 - \$299    | Circle of Friends    |
| <input type="checkbox"/> \$300 - \$499    | Support Group Circle |
| <input type="checkbox"/> \$500 - \$999    | WM Family Circle     |
| <input type="checkbox"/> \$1000 - \$2499  | Caregiver Circle     |
| <input type="checkbox"/> \$2500 - \$4999  | President's Circle   |
| <input type="checkbox"/> \$5000 and above | Trustee Circle       |

*(All Gifts Are Tax Deductible – Contact your tax advisor to verify a deduction applies to you)*

The IWMF is a registered 501(c) (3) non-profit corporation.

I wish to make a **single gift** of \$\_\_\_\_\_

I wish to make a recurring **monthly gift** of \$\_\_\_\_\_ beginning on the  **5<sup>th</sup> day** or  **20<sup>th</sup> day** of next month, to continue until I advise you otherwise. **A minimum of \$25 a month is suggested.**

I wish to make a recurring  **monthly**  **quarterly**  **annual gift pledge** of \$\_\_\_\_\_ for a total gift of \$\_\_\_\_\_ beginning on the  **5<sup>th</sup> day** or  **20<sup>th</sup> day** of next month and continuing for the next \_\_\_\_\_ years. **A maximum of 5 years and a minimum of \$25 for the monthly pledge are suggested.**

#### **Optional:**

My company will match this gift. I will send the required form to IWMF business office listed below.



If you have chosen one of the recurring options above please be advised that your credit card or bank account will be debited on or around the specified dates. You must check the box below to acknowledge that you are aware of and understand that your credit card or bank account will be debited on a recurring basis:

I acknowledge the terms above

### IWMF Gift Payment Information

#### Method of Payment:

- Check payable to IWMF  
(For recurring gifts please enclose a blank check with SAMPLE written across the front)
- Credit Card     VISA     MasterCard     American Express

Card No \_\_\_\_\_ Expiration Date \_\_\_\_\_ CVV \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_

### Additional information for In Honor and In Memory gifts

#### Personalization

To \_\_\_\_\_

In Honor or Memory of \_\_\_\_\_

From \_\_\_\_\_

- I wish to make the above gift In Honor of a WM survivor  
 I wish to make the above gift In Memory of a WM patient

#### Name and address of person to be advised of your gift:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip / Postal Code \_\_\_\_\_ Country \_\_\_\_\_

#### Please return completed forms to the IWMF Business Office:

3932D Swift Road  
Sarasota, FL 34231, USA  
Phone: 941-927-4963; Fax: 941-927-4467