

Donor Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: (h/w) \_\_\_\_\_ (cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Spouse Name (if applicable): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse Phone #: (h/w) \_\_\_\_\_ (cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Full Address: \_\_\_\_\_

- I/We wish to be referred to as \_\_\_\_\_ in donor recognition materials **OR**  
 I/We prefer to remain anonymous and do not wish to be recognized publicly at this time.  
 I/We approve the use of our name(s) for marketing/solicitation materials.

***I/We are pleased to acknowledge that I/we have named the Center for Disability Services as a beneficiary in my/our:***

- Will/Living Trust
- Retirement Plan
- Life Insurance Policy
- Payable on Death Account/Transfer on Death Asset
- Charitable Remainder Trust
- Charitable Gift Annuity
- Supplemental Needs Trust
- Other \_\_\_\_\_

***Please attach a copy of the appropriate documentation if possible.***

***The estimated value of my gift is:***

- \$ \_\_\_\_\_
- \_\_\_\_\_ % of my estate/retirement plan/life insurance, which is currently valued at \$ \_\_\_\_\_
- Other (please explain): \_\_\_\_\_
- Not known

***Additional Account Information (optional):***

\_\_\_\_\_

Signature of Donor: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse (if applicable) \_\_\_\_\_ Date: \_\_\_\_\_

Return this form to: Center for Disability Services, Attn: K. Heunemann, 22 Corporate Woods, Albany, NY 12211  
(518) 832-6113 ~ www.cfdsny.org ~ email: [heunemann@cfdsny.org](mailto:heunemann@cfdsny.org)