Bequest Notification Form

Directions: This form should be completed if the American Association of Psychiatric Pharmacists Foundation (AAPPF) has been included in an estate plan.

Disclaimer: This form is non-binding and does not constitute a legal promise of any future donation to the AAPP Foundation. The Foundation Board of Directors understands that bequests are revocable and that your estate plans may change. If willing, please include a copy of the completed will or appropriate document along with the bequest notification form.

Contact Information for Bequest Donor(s)

DONOR #1

Full Name: _____

Mailing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Date of Birth: _____

Phone: _____

Email Address: _____

DONOR #2 (if applicable)

Full Name: _____

Mailing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Date of Birth: _____

Phone: _____

Email Address: _____

(Please notify us of changes in your mailing or email address so we can stay in touch with you)

Type of Bequest

Please describe the provision for the AAPP Foundation in your estate planning below.

I/We have included the AAPP Foundation as a beneficiary of the following asset(s) and/or estate as described below:

☐ Retirement plan(s): _____

☐ Financial or investment account(s): _____

☐ Life insurance policy(ies): _____

☐ Other asset(s) (describe): _____

☐ A percentage of my/our estate, for a percentage of _____%

☐ A percentage of my/our residual estate, for a percentage of ____%

☐ A fixed amount of my/our estate: $_____

☐ I/We have left my/our entire estate for the benefit of AAPP Foundation.

Directions to AAPPF Regarding Requested Use of Bequest Funds

Upon receipt by the AAPP Foundation of donated bequest funds, I/we would like the funds to be used to specifically support:

_____

Permission for Public Identification

With your permission, we would like to include your name(s) in our AAPP Foundation listings which appear in our print and electronic publications and on signage at AAPP's Annual Meeting. Please indicate your preference for publishing your name(s).

☐ I/We would like others to be encouraged by my/our example. In published recognitions, please list me/us as: _____

☐ I/We would like to be listed as members of the Legacy Partners Society, the planned giving society of AAPP Foundation. Please list me/us as follows:

_____

☐ I/We would like to remain anonymous and prefer that my/our names(s) not be published.

Contact Information for Your Estate Executor

Full Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Email _____

Today's Date: Click or tap to enter a date.

Electronic Signature: _____

Please return the completed form by email or mail to:

American Association of Psychiatric Pharmacists Foundation
8055 O Street, Suite S113
Lincoln, NE 68510
Email: info@aappfoundation.org

Phone: 402-476-1677
501(c)3 Tax ID #: 27-1597907

Thanks so much for completing this form for our records.