



Monthly Donation Pledge Program

Please fill out this form to become a member of WellCare Foundation's monthly donation program.

Please return this form to:

WellCare Foundation
55 E. Lexington Avenue
Phoenix, AZ 85012

1. Donation Information

Mr. Mrs. Ms. Dr.

First Name: _____ MI: _____ Last Name: _____

Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

How would you like to receive acknowledgement/receipt of your donation? (Please check one)

- Monthly Acknowledgement
- Annual Summary

2. Payment Information

I would like to make a monthly pledge of \$ _____ for _____ months

I would like to donate to WellCare by: Credit Card Check

Please mail your check payable to **WellCare Foundation**
If donating by check, WellCare Foundation will send you a monthly reminder.

I authorize WellCare Foundation to make a monthly charge of the amount indicated above on my credit card. I understand that I need to contact WellCare Foundation for any changes to my monthly donation or to cease this agreement.

Card Type (check one): Visa MasterCard Discover

Card No.: _____ Expiration Date: _____ / _____ V-Code: _____

Authorized Start Date (month/year): _____

Signature: _____ Date: _____

Note: This transaction will occur on the 15th of the month.

All gifts to WellCare Foundation are tax deductible to the extent allowable by law.

Thank you for your generous support!!!

Tax ID #: 86-0948883