Donor-Advised Fund-Change Form

Complete this form to change your donor-advised fund information. You can change the fund name, contact information, advisors and/or successors for an existing donor-advised fund. Please complete and sign the form and return by mail to: New Jersey Health Charitable Gift Fund, 120 Albany St., Tower II, Suite 850, New Brunswick, NJ 08901. Additional forms are available at www.njhealthcharitable.org or by calling 908-315-5870.

1. Current Donor-Advised Fund Information

Fund Name ____

Primary Advisor ____

2. Donor-Advised Fund Name Change

New Donor-Advised Fund name ____

May we list your new fund name in our Annual Report? Yes No

3. Primary Advisor Change

Any changes to the Primary Advisor's address will become your account's primary address for all correspondence unless otherwise noted.

Mr. Mrs. Ms. Dr.

____ ___ ____________________

First Name, MI, Last Name Date of Birth

____

Street Address

____ ___________

City/State Zip code

_________________________________ ______________________

Email Primary Telephone #

4. Joint or Secondary Advisor Change(s)

Change, delete or add an Advisor below. To indicate additional changes, please attach a separate sheet.

Change **Delete** **Add** as a: Joint Advisor Secondary Advisor

Mr. Mrs. Ms. Dr.

____ ____________________

First Name, MI, Last Name Date of Birth

____

Street Address

____ ____________________

City/State Zip code

___________________________________ ____________________________

Email Primary Telephone #

Change **Delete** **Add** as a: Joint Advisor Secondary Advisor

Mr. Mrs. Ms. Dr.

____ ____________________

First Name, MI, Last Name Date of Birth

____

Street Address

____ ______________

City/State Zip code

___________________________________ ____________________________

Email Primary Telephone #

5. Successor Advisor or Charitable Beneficiary Change(s)

Change, delete or add a Successor Advisor OR a Charitable Beneficiary below. To indicate additional Successor changes, attach a separate sheet. In the event that a Charitable Beneficiary no longer exists, New Jersey Health Foundation Inc.'s Board of Directors will award grants to a charity whose mission is similar to the original charity.

A. Successor Advisor

Change **Delete** **Add**

Mr. Mrs. Ms. Dr.

____ ____________________
First Name, MI, Last Name Date of Birth

____
Street Address

____ _____________
City/State Zip code

_____________________________________ _________________________
Email Primary Telephone #

B. Charitable Beneficiary

Change **Delete** **Add as a Charitable Beneficiary**

Option 1: Distribute all remaining assets in the fund to the following charity **OR**

Option 2: Designate a specific percentage to be annually distributed to the charity

____ ____________________
Charity Name Annual % (Option 2 only)

____
Street Address

____ _____________
City/State Zip code

_________________________________ __________________ _________________
Contact name Telephone # Employer ID (if known)

6. Acknowledgement of Terms and Signature

By signing below, I consent to the changes included on this form. I certify that, to the best of my knowledge, all information in connection with this form is accurate and I will notify New Jersey Health Charitable Gift Fund in writing of any additional changes.

Form must be signed by the Primary Advisor and Joint Advisor, if any.

____ ____________
Signature Date

____
Primary Advisor (please print)

____ ____________
Signature Date

____
Joint Advisor (if any) (please print)

Please return this completed form by mail to:

New Jersey Health Charitable Gift Fund
120 Albany Street, Tower II, Suite 850 / New Brunswick, NJ 08901