Your support means everything to us!

Please print, complete, and mail this form with your check or credit card information.
Contact Deane Beebe at 212-204-6248 or dbeebe@medicarerights.org with any questions.

Your Information

Name (circle one) Mr./Mrs./Ms. ______________________________

Organization ______________________________

Address ______________________________

City ______________ State/Province ______________ Zip ______________

Country ______________ Email ______________________________

Donation Amount

I am making a gift of:

☐ $35 ☐ $50 ☐ $100 ☐ $250 ☐ $500 ☐ $1000 ☐ Other $ ______________

This gift is on behalf of: ☐ Myself ☐ My Company/Organization

I would like to make a:

☐ One-time contribution

☐ Recurring contribution:

(circle one) Every month Every 6 months Every year

☐ Donation through a Donor-Advised Fund:

______________________________ (name of fund)

Please turn over to enter payment information.

Payment Information

Name (as it appears on card) ______________________________

Credit Card Number ______________________________

Expiration Date ____________ (MM/YY) ____________

Credit Card (circle one):

VISA

I authorize the Medicare Rights Center to charge my credit card for the amount indicated on this form:

Signature ______________________________

☐ Please contact me to discuss my employer's gift match

☐ I wish for my donation to remain anonymous

Make check payable to Medicare Rights Center.

Mail this form to:
ATTN: Donations Processing
Medicare Rights Center
266 West 37th Street
3rd Floor
New York, NY 10018

Is this a tribute donation?

This gift is: ☐ in honor of ☐ in memory of:

Name ______________________________

Send announcement to:

Name ______________________________

Address ______________________________

City ______________ State/Province ____________ Zip ____________

Country ____________ Email ______________________________