Matching Gifts Program Request Form

Employee Instructions:
- Complete Part 1 of this form – one for each gift. *Please print or type.*
- Send the form with your contribution (Check or Credit Card Receipt) **to the recipient organization**.

Recipient Organization Instructions:
- Verify receipt of gift.
- Complete Part 2 of this form. *Please print or type.*
- If this is your first matching gift request to the Blue Shield of California Matching Gifts Program, please enclose a copy of your Internal Revenue Service 501(c)(3) IRS determination letter and a brief description of your organization's primary mission statement or purpose.
- Forward form to the address printed below.

PART 1 - DONOR SECTION

EMPLOYEE ID NUMBER

EMPLOYEE NAME

OFFICE ADDRESS

CITY/STATE/ZIP

BUSINESS TELEPHONE, INCLUDING AREA CODE

E-MAIL ADDRESS

EXACT DATE OF GIFT

$ **AMOUNT OF GIFT (MIN $20)**

$ **AMOUNT TO BE MATCHED (MIN $20)**

Type of gift: Please check one:
☐ Check ☐ Credit Card

Type of Match: Please check one:
☐ Employee Match ☐ Board Match*
**if you are a board member of this organization*

Type of Organization: Please check one:
☐ Domestic Violence
☐ College or graduate school
☐ Healthcare-related ☐ School, K-12
☐ Coverage for uninsured ☐ Arts & Culture
☐ Environment ☐ Social Service

Special Notes (donation is in *Memory of*, *In Honor of, For a Specific Walker or Participant,* etc.)

I certify that neither my family nor I will derive any direct or indirect financial or material benefit from this contribution. I authorize the above-named recipient organization to report this gift to Blue Shield of California for the purpose of applying for a matching gift. I certify that my gift is a voluntary contribution, that it fully complies with the provisions of the program described herein, and does not represent in anyway a fee for a service or benefit. Any misrepresentation by me of the statements made herein will forfeit my rights to any matching contributions and, in addition, may result in violations of law. In addition, I certify that I have not been nor will be reimbursed by anyone for this contribution. I have read and understood the guidelines of the Xyz Matching Gifts Program.

SIGNATURE OF EMPLOYEE **DATE**

PART 2 - RECIPIENT ORGANIZATION SECTION

EMPLOYER IDENTIFICATION NUMBER (EIN)

ORGANIZATION NAME

ADDRESS

CITY/STATE/ZIP

TELEPHONE, INCLUDING AREA CODE **FAX, INCLUDING AREA CODE**

E-MAIL **WEBSITE ADDRESSES (IF ANY)**

DATE GIFT RECEIVED

$ **AMOUNT OF GIFT**

$ **TAX DEDUCTIBLE GIFT AMOUNT**

I hereby certify that this organization/program meets the eligibility requirements of the Blue Shield of California Matching Gifts Program, and that neither the donor nor Blue Shield of California will derive any personal material benefit from this gift or match.

AUTHORIZED OFFICER'S NAME (PLEASE PRINT)

TITLE (PLEASE PRINT)

SIGNATURE OF AUTHORIZED OFFICER **DATE**

RECIPIENT ORGANIZATION: MAIL COMPLETED FORM AND ANY REQUIRED ENCLOSURES TO:

Blue Shield CARES Matching Gifts Program
P.O. Box 8319
Princeton, NJ 08543-8319

Phone: 1-866-625-4277
E-mail: blueshieldcares@easymatch.com
Web Site: www.easymatch.com/blueshieldcares