DONATION FORM

To make a gift to the KKH Health Fund, please fill in the following details where applicable. For monthly donations via GIRO, please fill in this form AND a separate BANK GIRO form (Refer to Annex A). Thank you for your generosity!

Personal / Company Details

All donations received are managed by SingHealth Fund (SHF), an Institution of Public Character (UEN 201624016E). All donors are required to provide their Tax Reference number (e.g. NRIC/FIN/UEN where applicable) to enjoy tax deduction. The donation will be automatically included in the donor's IRAS tax assessment. As such, we will not be sending any official receipt, unless upon written request by the donor.

☐ **Individual**

Name: (Dr / Mr / Mrs / Ms /Mdm) _____

Address: _____

Tel: (hp) _____ (h) _____ (o) _____

NRIC No: _____ Email: _____

☐ **Corporate**

Company name and Company stamp: _____

Address: _____

Contact person: (Dr / Mr / Mrs / Ms /Mdm) _____

Department / Designation: _____

Tel: (hp) _____ (o) _____

Company Registration No: _____ Email: _____

KKH
HEALTH FUND
Part of SingHealth Fund

I would like to make a gift to:

- ☐ General Fund
  Amount: _____
- ☐ Education and Research
  Amount: _____
- ☐ Rare Diseases Fund
  Amount: _____
- ☐ Premmies Fund
  Amount: _____
- ☐ Child Life Therapy
  Amount: _____
- ☐ Needy Patient Fund
  Amount: _____
- ☐ Kidz Horizon Appeal Fund
  Amount: _____
- ☐ Cancer Fund
  Amount: _____
- ☐ Vulnerable Mothers Programme
  Amount: _____

Preferred Contribution

☐ **Monthly Contribution**

With effect from: _____(day) _____ (month) _____(year)

☐ **One-time Gift**

Donation mode

☐ I would like to make my one-time contribution by cheque.

Cheque of S$ _____ (Bank & Cheque No. _____)
Cheque should be made payable to: ***SHF-KKH Fund***

☐ I would like to make my one-time / monthly contribution by credit card.

VISA / Mastercard / American Express card (please delete as appropriate)

Card No: _____ Expiry date: _____

Signature:_____ Date:_____

☐ I would like to make my monthly contribution by GIRO (please complete GIRO form)

For monthly donations, you may cancel your pledge any time by giving the KKH Health fund a one-month's written notice.

How did you get to know us?

☐ KKH Website ☐ Newspapers/Magazines ☐ Facebook ☐ Family/friends ☐ E-card

Others (please specify) :_____

PERSONAL DATA PROTECTION

By providing my particulars as requested in this form, I, the Donor understand and acknowledge that I am deemed to have given consent to the relevant SingHealth organisations and their successors or assigns (collectively 'Organisations' as detailed in the SingHealth Data Protection Policy) collecting, using and/or disclosing my personal data, and disclosing my personal data to each other (as may be necessary) for the purpose of processing my donations and such other reasonably related purposes as may be set out in the SingHealth Data Protection Policy available at www.singhealth.com.sg/pdpa.

In Addition:

☐ I agree to any of the SingHealth Organisations sending me information and/or contacting me via voice call or SMS on their fundraising campaigns, volunteer recruitment, social outreach and other related topics and events. I confirm and agree that my consents granted herein do not supersede or replace any other consents which I may have previously provided to each of the Organisations in respect of my personal data, and are additional to any rights which the Organisations may each individually have at law to collect, use or disclose my personal data.

☐ By ticking this box, I wish to remain anonymous and my personal data/ donation should not be publicised or recognised in any form.

You can send your completed donation form to:

KKH Health Fund
c/o Development Department, Children's Tower, Level 3
KK Women's and Children's Hospital
100 Bukit Timah Road
Singapore 229899
Email: kkhhf@kkh.com.sg

Thank you for your donation!

ANNEX A

KKH Health Fund
KK Women's and Children's Hospital
100 Bukit Timah Road Singapore 229899

APPLICATION FROM FOR INTERBANK GIRO
Please complete PART I of this form and return to the Billing Organisation.

PART I **For Donor's Completion**

To : The Manager (Name & Address of Bank)

MY / OUR BANK A/C NAME

MY / OUR BANK A/C NO.

LIMIT OF EACH PAYMENT (exclude cents)*

* *Please indicate the maximum amount of each payment if you wish to set a limit for each payment*

NOTE : THE SHADED AREA IS FOR OFFICIAL USE. ☐

NAME OF BILLING ORGANIZATION
SHF-KKH FUND

DONOR'S NAME

DONOR'S IC / PASSPORT / RCB NO.

(a)I/We hereby authorise you to confirm acceptance/rejection of my DDA to the Billing Organisation SHF-KKH Fund and further authorise the Billing Organisation to initiate and you to process debits to my/our account each not exceeding the limit indicated even though this may result in an overdraft or an increase of the overdraft on my/our account. You are entitled to dishonour such payments and may at your discretion levy a fee should my/our account not contain the necessary funds. You are under no obligation to ascertain the name on the record of the Billing Organisation is the same as that provided by me/us and whether or not notice of the bill underlying the debit has been given to me/us.

(b)The authorisation shall continue in force until I/we have expressly revoked it by written notice delivered to you. You may in your absolute discretion terminate this arrangement by written notice delivered to me/our address last known to you.

(c) I/We agree that you shall not be liable for any losses arising from or in any way connected with you so acting, provided that you act in good faith or unless directly caused by or resulting from you or your employees' wilful default or negligence.

My/Our Signature(s) [According to Bank's specimen signature(s)] Date

PART II **For SHF-KKH Fund's Official use only**

SWIFT BIC	BILLING ORGINISATION'S BANK A/C NO.
DBSSSGSG	0 | 0 | 3 | - | 9 | 4 | 5 | 3 | 4 | 9 | - | 3

BILLING ORGAN'S CUST'S REF NO.
| | | | | | | | | | |

SWIFT BIC	A/C NO. TO BE DEBITED
	| | | | | | | | | |

LIMIT OF EACH PAYMENT (exclude cents)
| | | | | | | | | | |

PART III **For Bank's Official use only**

To : The Manager (Name & Address of Billing Organisation)

Attn :

SWIFT BIC	BILLING ORGINISATION'S BANK A/C NO.
	| | | | | | | | | | |

BILLING ORGAN'S CUST'S REF NO.
| | | | | | | | | | |

SWIFT BIC	A/C NO. TO BE DEBITED
	| | | | | | | | | | |

LIMIT OF EACH PAYMENT (excludes cents)
| | | | | | | | | | |

The Direct Debit Authorisation in respect of the account mentioned herein is hereby +ACCEPTED / REJECTED.

If rejected, reason :

Authorised Signature

Name of Approving Officer :

Name of Bank :

Verified By Billing Organisation	

+ delete inapplicable