ABLE United

Add/Edit/Remove Successor Designated Beneficiary Form

Important information about using this form:

- Before completing this form, carefully read the **Program Description & Participation Agreement**.
- Fill out this form to add, edit, or remove a Successor Designated Beneficary from an ABLE United account.
- The Successor Designated Beneficary is eligible to inherit the account if the Beneficiary dies or becomes incapacitated. By law, a Successor Designated Beneficary for an ABLE United account must be a sibling, step-sibling, or half-sibling of the designated beneficiary, and must also have a qualifying disability.
- If something happens to the Beneficiary, the Successor Designated Beneficary should contact customer service to assume the responsibility for the account. They will need to provide legal documentation (e.g. Death Certificate or other legal documents), as well as proof of their eligible disability.

Need help?
Give us a call Monday – Friday from 9am – 6pm ET at **1-888-524-2253**

Individuals with speech or hearing disabilities may dial 711 to access Telecommunications Relay Service (TRS) from a telephone or TTY.

Mail the form to:
ABLE United
PO Box 534422
Pittsburgh, PA 15253- 4422

Overnight Mail:
ABLE United
Attention: 534422
500 Ross Street, 154-0520
Pittsburgh, PA 15262

Fax:
833-337-7250

1 ABLE United Account information

_____

Name of the Beneficiary on the ABLE United account (First and last)

__ __ __ – __ __ – __ __ __ __

Beneficiary's Social Security or Taxpayer Identification Number

A U – __ __ __ __ __ __ __ __ __ __ __

ABLE United account number

2 Manage Successor Designated Beneficiary information

(Please select one)

◯ Add a Successor Designated Beneficary

◯ Change the Successor Designated Beneficary

◯ Remove the Successor Designated Beneficary (Skip to **Step 4**)

3 Successor Designated Beneficiary information

This information is needed to confirm the Successor Designated Beneficary's eligibility for this ABLE United account.

_____

Successor Designated Beneficiary name (First and last)

__ __ / __ __ / __ __ __ __

Date of birth (mm/dd/yyyy)

__ __ __ – __ __ – __ __ __ __

Social Security or **Taxpayer Identification Number**

Residential address

No P.O. boxes are accepted for a residential address.

_____

Street address 1

_____

Street address 2

_____

City

_____ __ __ __ __ __ – __ __ __ __

State ZIP Code

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Which option applies to the Successor Designated Beneficiary? (Please select one)
I certify under the penalties of perjury that:

◯ The Successor Designated Beneficary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act.

◯ The Successor Designated Beneficary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act.

◯ The Successor Designated Beneficary

a. has a medically determinable physical or mental impairment that results in marked and severe functional limitation* and can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; OR is blind†

AND

b. has a signed diagnosis (see our **Physician's Form**) from a licensed physician‡ as to the condition described in (a)

The Plan does not require you to submit documentation regarding the disability, but the IRS or Social Security Administration reserves the right to request this documentation and therefore you should retain proof in your personal records.

* I understand that "marked and severe functional limitation" means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the "Listing"), but without regard to age. The Listing can be found at https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary's prescribed treatment.

† I understand that, for purposes of eligibility for an ABLE account, "blind" means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a doctor of medicine (MD) or a doctor of osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502(a).

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Diagnosis Code (Please select one)

- ◯ Code 1: Developmental Disorder
  Autistic Spectrum Disorder, Asperger's Disorder, Developmental Delays and Learning Disabilities
- ◯ Code 2: Intellectual Disability
  Mild, moderate, or severe intellectual disability
- ◯ Code 3: Psychiatric Disorder
  Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD), Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD) and Bipolar disorder
- ◯ Code 4: Nervous Disorder
  Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease, Multiple sclerosis, Severe sensorineural hearing loss and Congenital cataracts
- ◯ Code 5: Congenital Anomalies
  Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum, Spinal muscular atrophy, Fragile X syndrome and Edwards syndrome
- ◯ Code 6: Respiratory Disorder
  Cystic Fibrosis
- ◯ Code 7: Other
  Anything not listed under codes 1-6 and Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease and Hemophilia

Is this disability permanent*? ◯ Yes ◯ No

I certify under the penalties of perjury that:

- ◯ The Successor Designated Beneficary developed the disability or blindness before the age of 26
- ◯ I will notify the Program of any changes to the permanence* of the Successor Designated Beneficary's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence
- ◯ The Successor Designated Beneficiary is a sibling, step-sibling, or half-sibling of the Designated Beneficiary.

Certification date __ __ / __ __ / __ __ __ __
(mm/dd/yyyy)

* Permanent/permanence is intended to mean a disability that "can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" as set forth in Section 529A of the Internal Revenue Code.

4 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **Program Description & Participation Agreement**. I understand and agree that those documents govern all aspects of this ABLE United account and are incorporated herein by reference.

I will retain a copy of the **Program Description & Participation Agreement** for my records. I understand that the ABLE United Program may, from time to time, amend the **Program Description & Participation Agreement**, and I understand and agree that I will be subject to the terms of those amendments.

I certify that all of the information provided by me on this form is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to change this ABLE United account based upon this information.

Signature of Beneficiary or Authorized Legal Representative

Date (mm/dd/yyyy)