ABLE United

Enrollment Form

Important information about opening a new account:

- Before completing this form, carefully read the **Program Description & Participation Agreement**.
- An eligible person can only have one ABLE account open at any time.
- Fill out all sections of this form to open a new ABLE United account.
- You'll need to make an initial contribution of at least $25 to start.
- If you connect a bank account to the ABLE account, the name of the Beneficiary or the Authorized Legal Representative must be associated with the bank account.
- Type or print clearly in black ink, and do not staple the pages or check.
- ABLE accounts are subject to a Maximum Annual Contribution Limit. See the Program Description & Participation Agreement (www.ABLEUnited.com/pdpa) for the current limit.
- If you're making an ABLE to Work contribution, you may contribute an amount equal to the Beneficiary's gross income, up to the Beneficiary's compensation for the taxable year; or an amount equal to the Federal Poverty Level for a one person household as determined for the preceding calendar year of the tax year in which contributions are made, in addition to the yearly standard contribution limit.

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
P.O. Box 9696
Providence, RI 02940-9696

Overnight Mail:
ABLE United
4400 Computer Drive
Westborough, MA 01581

1 Is this a rollover from another ABLE plan?

◯ Yes (Please also fill out one of the applicable **Rollover Forms** in addition to this form. You can find forms at https://www.ableunited.com/resources/forms-and-publications/)

◯ No

2 Beneficiary information

_____ __ __ / __ __ / __ __ __ __

Name (First and last) **Date of birth** (mm/dd/yyyy)

How does the Beneficiary identify? ◯ As she ◯ As he ◯ Chooses not to identify

__ __ __ – __ __ – __ __ __ __ __ __ __ – __ __ __ – __ __ __ __

Social Security or Taxpayer Identification Number **Telephone number**

continued from page 1

Residential address

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

Street address 1

Street address 2

City

State

ZIP Code

Does the Beneficiary self-identify as a veteran? ◯ Yes ◯ No

3 Authorized Legal Representative (ALR) information — If applicable

If you are an ALR please complete this step. If not, continue to Step 4.

If the Beneficiary is not able to exercise signature authority over their ABLE account or chooses to establish an ABLE account but not exercise signature authority, an ALR may act on the Beneficiary's behalf with respect to the account. If an ALR establishes an ABLE Account, the ALR must self-attest/certify to the basis for acting as the ALR and must also certify that there is no person with a higher priority.

The priority for opening an account as an ALR is as follows in this order: an individual selected by the eligible beneficiary with legal capacity, an individual's agent under a power of attorney, a conservator or legal guardian, a spouse, parent, sibling or grandparent, or a Social Security Administration representative payee (individual or organization).A person may self-attest/certify that they are authorized to open the ABLE account and there is no other person higher in order willing to establish the account. According to Internal Revenue Service ("IRS") guidance, the ALR may neither have, nor acquire, any beneficial interest in the ABLE Account during the Beneficiary's lifetime and must administer the ABLE Account for the benefit of the Beneficiary. Whenever an action is required to be taken by a Beneficiary in connection with a ABLE Account with an Authorized Legal Representative, it must be taken by the Beneficiary's ALR acting in that capacity.

Name (First and last)

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Relationship to the Beneficiary (Please select one)
I certify under the penalties of perjury that I am the Beneficiary's:

- ◯ **Power of Attorney**
  I have the Power of Attorney to open and manage an ABLE account for the Beneficiary.
- ◯ **Legal Guardian**
  The Beneficiary does not have a Power of Attorney pertaining to this ABLE account, and I am their legal guardian.
- ◯ **Conservator**
  The Beneficiary does not have a Power of Attorney pertaining to this ABLE account and I have been appointed conservator.
- ◯ **Spouse**
  I have the authority to open and manage an ABLE account for the Beneficiary.
- ◯ **Parent**
  I have the authority to open and manage an ABLE account for the Beneficiary.
- ◯ **Sibling**
  I have the authority to open and manage an ABLE account for the Beneficiary.
- ◯ **Grandparent**
  I have the authority to open and manage an ABLE account for the Beneficiary.
- ◯ **Representative Payee**
  I have the authority to open and manage an ABLE account for the Beneficiary.

__ __ / __ __ / __ __ __ __
Date of birth (mm/dd/yyyy)

__ __ __ – __ __ – __ __ __ __
Social Security or Taxpayer Identification Number

__ __ __ – __ __ __ – __ __ __ __
Telephone number

Residential address

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

◯ Authorized Legal Representative has the same address at the Beneficiary
(Leave address information below blank)

_____ _____
Street address 1 **Street address 2**

_____ _____ __ __ __ __ __ – __ __ __ __
City **State** **ZIP Code**

4 Communication preferences

Mailing address

P.O. boxes are accepted for a mailing address.

- ◯ Use the Beneficiary's residential address as the mailing address
  (Leave address information below blank)
- ◯ Use the Authorized Legal Representative's residential address as the mailing address
  (Leave address information below blank))

Street address 1 _____ Street address 2 _____

City _____ State _____ ZIP Code _____ – _____

Choose how you want to receive statements and tax forms for all the accounts you manage
(Please select one)

- ◯ Send digital tax forms, account information and quarterly statements by email
  (Please answer **Step 4A** below)
- ◯ Send digital quarterly statements and account information by email, but send tax forms by U.S. mail*
  (Please answer **Step 4A** below)
- ◯ Send quarterly statements, account information and tax forms by U.S. mail*
  (You'll be charged $10 per account, per year)

A **What email address should we use?**
Answer if you've chosen to receive items by email

Email _____

Want an easier way to enroll?
Go online to www.ABLEUnited.com and use your email to set up an account.

* All documents sent by U.S. mail will be mailed to the account's mailing address.

5 Diagnosis Information

This information is needed to confirm the Beneficiary's eligibility for the ABLE program.

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

- ◯ The Beneficiary 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 Beneficiary 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 Beneficiary
  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)

  I understand that I am required to retain such signed diagnosis and to provide it to the Program or the IRS upon request, and I agree to do so.

* 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 www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm. 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.

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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 Beneficiary developed the disability or blindness before the age of 26
- ◯ The Beneficiary has no other ABLE account
- ◯ I will notify the Program of any changes to the permanence* of the Beneficiary's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence

* 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.

6 Work information

Providing employment information will help us understand how the account is being funded.

What is the Beneficiary or Authorized Legal Representative's work status? (Please select one)

◯ Employed ◯ Self-Employed ◯ Retired or Not Working

A **What's your occupation** (Please select one)

Answer if **employed** or **self-employed**:

- ◯ Accounting/Auditing
- ◯ Admin/Clerical
- ◯ Art/Antiques Dealer
- ◯ Banking Professional
- ◯ Car/Boat/Airplane Dealer
- ◯ Casino/Gaming
- ◯ Construction/Skilled Trade
- ◯ Creative/Design/ Architectural
- ◯ Defense/Military
- ◯ Editorial/Writing/Publishing
- ◯ Education
- ◯ Elected Official/Embassy
- ◯ Engineering/Science/R&D
- ◯ Entertainment/Sports/Arts
- ◯ Financial Services
- ◯ Health Care Professional
- ◯ Hospitality/Food
- ◯ Independent Investor
- ◯ Information Technology
- ◯ Insurance
- ◯ Legal Services
- ◯ Manufacturing/Production
- ◯ Nonprofit Executive
- ◯ Operations
- ◯ Other:

_____

(Please write in your occupation)

- ◯ Public Service
- ◯ Retail/Sales/Real Estate
- ◯ Student
- ◯ Transportation/ Warehousing

B **Please choose all of your sources of income** (Select all that apply)

Answer if **retired or not working**:

- ◯ Retirement Savings
- ◯ Spousal Support
- ◯ Social Security or Pension
- ◯ Other Government Services
- ◯ Other:

_____

(Please write in all other sources)

7 Successor Owner information - optional

This information is needed to confirm the Successor Owner's eligibility for this ABLE United account.The Successor Owner is eligible to inherit the account if the Beneficiary dies or becomes incapacitated. By law, a Successor Owner 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.

Successor Owner name (First and last)

__ __ / __ __ / __ __ __ __ **Date of birth** (mm/dd/yyyy)

__ __ __ – __ __ – __ __ __ __ **Social Security** or **Taxpayer Identification Number**

Street address 1

Street address 2

City

State

__ __ __ __ __ – __ __ __ __ **ZIP Code**

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

- ◯ The Successor Owner 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 Owner 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 Owner
  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)

  I understand that I am required to retain such signed diagnosis and to provide it to the Program or the IRS upon request, and I agree to do so.

* 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 www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm. 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.

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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 Owner developed the disability or blindness before the age of 26

◯ I will notify the Program of any changes to the permanence* of the Successor Owner's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence

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.

8 Contribution information

There's a $25 minimum contribution to open an account and you must contribute at least $5 to each portfolio or fund you want to add money to. You can connect a bank account (**Step 10**) or include a check made out to ABLE United.

You can select as many portfolios you want to invest your initial and future contributions. You can view your portfolio allocations at any time or change your investment strategy up to twice per calendar year.

Please read the ABLE United Program Description & Participation Agreement for important information about the cash and investment options before making a decision.

Investment options

Conservative Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Moderate Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Growth Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
U.S. Stock Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
International Stock Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
U.S. Bond Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Money Market Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
FDIC Savings Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
	$ ___ ___ , ___ ___ ___ . ___ ___ **Total contribution amount**

The investment information on this page has been provided by Aon, the investment advisor for the ABLE United Program.

How are you making this contribution?

◯ Check (Please include a check made out to ABLE United with a paper clip, do not staple)

◯ ACH deposit (Please fill out **Step 10**)

Which type of contribution are you making? (Please select one)

◯ Standard contribution
ABLE accounts are subject to a Maximum Annual Contribution Limit. See the Program Description & Participation Agreement (www.ableunited.com/pdpa) for the current limit.

◯ ABLE to Work contribution
If a Beneficiary is working and his/her employer does not contribute to the Beneficiary's defined contribution plan, 403(b), or 457(b) plan within the taxable year, the Beneficiary may contribute an additional amount up to the lesser of: (i) the Beneficiary's compensation for the taxable year; or (ii) an amount equal to the Federal Poverty Level for a one person household as determined for the preceding calendar year of the tax year in which contributions are made.

9 Monthly contribution information — If applicable

Skip this step if you don't want to set up a monthly contribution at this time. You can set up monthly contributions in the future online.

By setting up a monthly contribution, this will authorize us to initiate recurring ACH debits (direct withdrawals) from your bank account on the day you indicate of each month for the amount you set. You may cancel or change these recurring ACH debits (direct withdrawals) online or by using the **Manage Monthly Contributions Form**; however, we must receive your request at least 3 business days before you want it to become effective. We will continue to process transactions scheduled to occur before the end of the 3rd business day after you tell us to stop.

Investment options

Conservative Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Moderate Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Growth Portfolio	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
U.S. Stock Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
International Stock Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
U.S. Bond Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
Money Market Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**
FDIC Savings Fund	$ ___ ___ , ___ ___ ___ . ___ ___ **Amount**

___ ___ **Day of the month** (1 – 28) If you don't pick a date, we'll automatically do it on the 1st of every month.	$ ___ ___ , ___ ___ ___ . ___ ___ **Total contribution amount**

Which type of contribution are you making? (Please select one)

◯ Standard contribution
ABLE accounts are subject to a Maximum Annual Contribution Limit. See the Program Description & Participation Agreement (www.ableunited.com/pdpa) for the current limit.

◯ ABLE to Work contribution
If a Beneficiary is working and his/her employer does not contribute to the Beneficiary's defined contribution plan, 403(b), or 457(b) plan within the taxable year, the Beneficiary may contribute an additional amount up to the lesser of: (i) the Beneficiary's compensation for the taxable year; or (ii) an amount equal to the Federal Poverty Level for a one person household as determined for the preceding calendar year of the tax year in which contributions are made.

10 Bank account information

If you choose to make regular deposits and withdrawals with an ACH bank transfer, attach a voided check or copy of your bank statement showing the name, address, last 4 digits of the account number and complete the bank information below. Please use a paper clip for the check (do not staple).

Bank account type ◯ Checking ◯ Savings

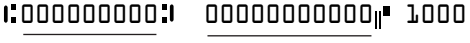
Name on bank account
The first and last name on the bank account needs to be the same as either the Beneficiary or the Authorized Legal Representative.

Bank name

Bank routing number

Bank account number

Need help?
You can find your bank information on the bottom of one of your checks here:



Routing Number | Account Number

11 Verify your identity

We need any individuals linked to this account over the age of 18 to provide identification.

How to provide identification

- ◯ If you are the Beneficiary, please include Acceptable ID Documentation for yourself
- ◯ If you are the Authorized Legal Representative **and the Beneficiary is under 18,** please include Acceptable ID Documentation for yourself
- ◯ If you are the Authorized Legal Representative **and the Beneficiary is over 18,** please include Acceptable ID Documentation for yourself and the Beneficiary

Acceptable ID Documentation

Option A
Include a copy of a Department of Motor Vehicles State ID

Option B
Include a copy of both your Social Security card and your birth certificate

To help the government fight the funding of terrorism and money laundering, federal law requires us to obtain certain personal information, including your name, address, date of birth, and Social Security number or taxpayer identification number and other information that will allow us to verify your identity. If we are unable to verify your identity, we may have to close your account or take other steps we think are necessary.

12 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 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 **Enrollment Form** is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to open this Account based upon this information.

Additionally, I certify under penalty of perjury:

- The Beneficiary's disability or blindness is expected to result in death or has lasted, or can be expected to last for a continuous period of not less than 12 months and that I will notify the Program of any change to the status of the beneficiary's disability or blindness (including any potential cure or remission of such disability or blindness) promptly upon such occurrence.
- If I've indicated that either my initial contribution or monthly contributions are ABLE to Work contributions I certify that the Beneficiary is earning wages and the amount being contributed is less than or equal to the Beneficiary's gross income this calendar year and is no more than the the Beneficiary's compensation for the taxable year; or an amount equal to the Federal Poverty Level for a one person household as determined for the preceding calendar year of the tax year in which contributions are made. I also certify if I'm making an ABLE to Work contribution that the Beneficiary (or the Beneficiary's employer) has not contributed to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year.
- I certify, under penalties of perjury, I am seeking to establish an ABLE account as the eligible individual or have been selected by the eligible individual with legal capacity, or if the eligible individual is unable to establish their own ABLE account, I have the authority to establish the ABLE account as an agent under a power of attorney or, if none, by a conservator or legal guardian, spouse, parent, sibling, grandparent of the eligible individual, or a representative payee appointed for the eligible individual by the Social Security Administration (SSA), in that order, and that there is no other person with a higher priority as listed above to establish the ABLE account.

Signature of Beneficiary or Authorized Legal Representative

Date (mm/dd/yyyy)