

Important notice to the person executing this document:

This is an important legal document. This power of attorney authorizes an Entity, you designate, as your proxy or Attorney-in-fact with the broad powers it sets forth, to make decisions concerning your ABLÉ account for you (the Beneficiary). Your proxy will be able to make decisions and act with respect to your ABLÉ account whether or not you are able to act for yourself. Unless you specify otherwise, generally the proxy's authority will continue until you die or revoke the power of attorney or the proxy resigns or is unable to act for you.

You have the right to terminate this power of attorney. If you have questions about the power of attorney or the authority you are granting to your proxy, you should seek legal advice before signing this form.

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

Name of the Beneficiary on the ABLÉ account (First and last)

ABLE United account number (If available)

Telephone number

I, _____
Name of the Beneficiary (First and last)

of _____
Address of Beneficiary

do hereby, make constitute and appoint _____
Name of the Attorney-In-Fact (Entity ALR's business name)

whose specimen signature is _____ as agent for _____
Signature of the Agent (First and last) (Entity ALR's business name)

and whose address is _____
Address of Attorney-In-Fact (entity ALR's buusiness address)

my true and lawful Attorney-in-Fact. All references herein to Attorney-in-Fact shall be to such Entity or Entity-appointed Agent.



Durable Power of Attorney and Indemnification Agreement for Power of Attorney Registration

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY-IN-FACT SHALL NOT TERMINATE IF I LATER BECOME INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

I give and grant, and have the legal capacity to grant, to my Attorney-in-Fact the power to act on my behalf with respect to the above referenced ABLE account, such power to be used for my benefit and to be exercised by my Attorney-in-Fact only in a fiduciary capacity. Specifically, my Attorney-in-Fact shall have the power:

- | | | | | |
|---|--|---|---|--|
| To deposit or invest funds owned wholly or partly by me in the above referenced ABLE account; | to withdraw, now or in the future, any funds from the above referenced ABLE account; | to select the investment option(s) for the contributions to the ABLE account; | to change the beneficiary of the above-referenced ABLE account; | to make representations and certifications on the beneficiary's behalf and to otherwise manage and enter into all other lawful transactions with respect to the above referenced ABLE account. |
|---|--|---|---|--|

_____ Beneficiary Initial	_____ Beneficiary Initial	_____ Beneficiary Initial	_____ Beneficiary Initial	_____ Beneficiary Initial
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I hereby agree to indemnify and hold Florida Prepaid College Board (the "Board"), Florida ABLE, Inc. d/b/a ABLE United ("ABLE United"), and each of their service providers, harmless from acting upon instructions, either oral or in writing, believed to have originated from said Attorney-in-Fact and from any and all acts of said Attorney-in-Fact with respect to my ABLE account.

The authorization and indemnity is a continuing one and shall remain in full force and effect and shall be binding upon the undersigned's heirs, executors, successors, beneficiaries, or assigns until revoked by the undersigned by a written notice addressed and delivered to ABLE United, P.O. Box 9696, Providence, RI 02940-9696. Such revocation shall not affect any liability in any way resulting from transactions initiated prior to ABLE United or the Board acting on such revocation within a reasonable amount of time. In case of the death, disability or incompetence of the undersigned, this authorization shall continue and ABLE United, the Board, or any of its affiliates, shall not be responsible for any action taken on the basis of this authorization until the ABLE United has received written notice thereof addressed to the ABLE United and delivered to ABLE United Savings Plan's address listed above.

Any grant of a Durable Power of Attorney made by me subsequent to the date of execution of this Durable Power of Attorney shall not revoke this Durable Power of Attorney, unless the subsequent Durable Power of Attorney contains a statement to the contrary and specifically refers to this Durable Power of Attorney by its date. Any person relying on this power of attorney may rely on a photocopy as if it were an original.

The undersigned has read the foregoing in its entirety before signing.

I have signed and sealed this Power of Attorney this _____ day of _____, 20____ .
Day (#) Month Year

Signature of Beneficiary

Beneficiary Name Printed

Witness #1 Signature

Witness #2 Signature

Witness #1 Name Printed

Witness #2 Name Printed

Keep in mind that:

- You're providing the following information as underwritten certification that your signature is genuine.
- You cannot guarantee your own signature. You may be required to provide proof of your authority to act on behalf of the ABLE Account.

Only sign if you are in the presence of a notary public or other officer providing notarization.

Name of the Attorney-In-Fact (First and last)

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of

physical presence or **online notarization**,

This ____ day of _____, 20____, by _____

Signature of Notary Public - State of Florida

Circle one:
Personally Known OR **Produced Identification**

Type of Identification Produced

Print, Type, or Stamp Commissioned Name of Notary Public

Affidavit of Attorney-In-Fact

STATE OF FLORIDA

COUNTY OF _____
County

I, _____ as agent for _____,
Name of the Agent (First and last) **Name of the Attorney-In-Fact** (Entity ALR's business name)

of lawful age, being duly sworn on his oath says that _____
Name of the Beneficiary (First and last)

as principle, who resides at _____,
Address of the Beneficiary

did on this _____ day of _____, 20____ appoint the Entity true and lawful attorney-in-fact by the
Day (#) Month Year

foregoing instrument hereby made a part hereof.

Signature of Agent signing on behalf of the Entity Attorney-In-Fact (First and last)

STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of

physical presence or **online notarization**,

This ____ day of _____, 20____, by _____

Signature of Notary Public - State of Florida

Circle one:
Personally Known OR Produced Identification

Type of Identification Produced

Print, Type, or Stamp Commissioned Name of Notary Public