MarylandABLE

Account Reopen Form

Important information about opening a new account:

- Use this form to reopen an account that was previously closed.
- The Beneficiary or the Authorized Legal Representative must sign this form.
- Keep in mind that all communications are sent to the mailing address and/or email address listed on this form.

Need help?
Give us a call Monday – Friday from 9am – 8pm ET at **1-855-563-2253**

Mail the form to:
Maryland ABLE
P.O. Box 534424
Pittsburgh, PA 15253-4424

Overnight Mail:
Maryland ABLE
Attention: 534424
500 Ross Street, 154-0520
Pittsburgh, PA 15262

Fax:
833-286-8170

1 ABLE account information

_____
Name of Beneficiary on the ABLE Account (First and last)

__ __ __ - __ __ - __ __ __ __
Beneficiary's Social Security or **Taxpayer Identification Number**

__ __ __ __ __ __ __ __ __
Maryland ABLE account number

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

_____ _____ __ __ __ __ __ - __ __ __ __
City **State** **Zip Code**

2 New Authorized Legal Representative information

Name (First and last)

Relationship to the Beneficiary (Please select one)

I certify under the penalties of perjury that:

- ◯ I have been selected by the beneficiary to establish this ABLE account on their behalf. (Mark **Selected by Beneficiary** below)
- ◯ The beneficiary is unable to establish their own able account; I am establishing it on their behalf.

I certify under the penalties of perjury that I am the highest person on the hierarchy below who is willing and able to serve as the ALR for the beneficiary.

- ◯ **Selected by Beneficiary**
  The Beneficiary has selected me to serve as their ALR with authorized signatory on the account. (Mark **only** if you have been selected by the Beneficiary)
- ◯ **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 PO boxes are accepted for a residential address.

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

_____ _____ __ __ __ __ __ - __ __ __ __
City **State** **Zip Code**

3 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 5A** below)

◯ Send digital quarterly statements and account information by email, but send tax forms by U.S. mail*
(Please answer **Step 5A** 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

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

4 Diagnosis information

Is the disability permanent? ◯ Yes ◯ No

I certify to the 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 Plan 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

5 Sign the form

By signing this form, you're confirming the information provided is true.

_____ __ __ / __ __ / __ __ __ __

Signature of Authorized Legal Representative **Date** (mm/dd/yyyy)