

### Important information:

- Use this form if the adult Beneficiary has reached the age of 18 and wishes to exercise signature authority and assume administrative duties on the account.
- If the Beneficiary is under the age of 18, please complete a **Change Authorized Legal Representative Form** instead.
- Before completing this form, carefully read the Plan Disclosure and Participation Agreement.
- An eligible person can only have one ABLE account open at any time.
- Fill out the **Bank Add/Change Request Form** to make updates to the banking information if it's affected by removing the Authorized Legal Representative.
- The adult Beneficiary must provide a notarization acknowledgement.
- Type or print clearly in black ink, and do not staple the pages.

### Need help?

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

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

### Mail the form to:

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

## 2 Beneficiary information

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
Date of Birth (mm/dd/yyyy)

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Telephone number

### Residential address

No PO boxes are accepted for a residential address.

\_\_\_\_\_  
Street address 1

\_\_\_\_\_  
Street address 2

\_\_\_\_\_  
City

\_\_\_\_ State      \_\_\_\_\_  
Zip Code

### 3 Communication preferences

#### Mailing address

PO boxes are accepted for a mailing address.

- Use the Beneficiary'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

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

**4 Work Information of the Beneficiary**

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**:

- |   |  |
|---|--|
| <input type="radio"/> Accounting/Auditing           | <input type="radio"/> Hospitality/Food           |
| <input type="radio"/> Admin/Clerical                | <input type="radio"/> Independent Investor       |
| <input type="radio"/> Art/Antiques Dealer           | <input type="radio"/> Information Technology     |
| <input type="radio"/> Banking Professional          | <input type="radio"/> Insurance                  |
| <input type="radio"/> Cannabis related business     | <input type="radio"/> Legal Services             |
| <input type="radio"/> Car/Boat/Airplane Dealer      | <input type="radio"/> Manufacturing/Production   |
| <input type="radio"/> Casino/Gaming                 | <input type="radio"/> Nonprofit Executive        |
| <input type="radio"/> Construction/Skilled Trade    | <input type="radio"/> Operations                 |
| <input type="radio"/> Creative/Design/Architectural | <input type="radio"/> Other:                     |
| <input type="radio"/> Defense/Military              | <hr/>  |
| <input type="radio"/> Editorial/Writing/Publishing  | (Please write in your occupation)                |
| <input type="radio"/> Education                     | <input type="radio"/> Public Service             |
| <input type="radio"/> Elected Official/Embassy      | <input type="radio"/> Retail/Sales/Real Estate   |
| <input type="radio"/> Engineering/Science/R&D       | <input type="radio"/> Student                    |
| <input type="radio"/> Entertainment/Sports/Arts     | <input type="radio"/> Transportation/Warehousing |
| <input type="radio"/> Financial Services            |  |
| <input type="radio"/> Health Care Professional      |  |

**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:

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 (Please write in all other sources)

**5 Verify your identity**

The Beneficiary must provide identification to prove their identity if they reached the age of 18 since opening the account.

**How to provide identification****Acceptable ID Documentation**

## Option A

Include a recent copy of a Department of Motor Vehicles State ID

## Option B

Include a copy of both your Social Security

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.

## 6 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 Maryland ABLÉ 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 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.

\_\_\_\_\_  
Signature of adult Beneficiary —

\_\_ / \_\_ / \_\_\_\_  
Date (mm/dd/yyyy)

**7 A notarization acknowledgement is required for the Adult Beneficiary**

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.**

The undersigned has read the foregoing in its entirety before signing. IN WITNESS WHEREOF, I have hereunto

set my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
Day (#) Month Year

\_\_\_\_\_  
**Signature of Beneficiary**

STATE OF MARYLAND, COUNTY OF \_\_\_\_\_  
County

This instrument was acknowledged before me

physical presence or  online notarization

on \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
Day (#) Month Year

by \_\_\_\_\_  
**Name of person** (first and last)

My term expires: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**Date** (mm/dd/yyyy)

**Notary Public (Seal)**

\_\_\_\_\_  
**Signature of Notary Public**