

### Important information about opening a new account:

- 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 all sections of this form to open a new Maryland ABLE account.
- You'll need to make an initial contribution of at least \$25 to start off the account.
- 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.
- See the Plan Disclosure and Participation Agreement for the current yearly standard contribution limit.
- If you're making an ABLE to Work contribution, you may contribute an amount equal to the Beneficiary's gross income (see Program Disclosure Booklet for current limits) in addition to the yearly standard contribution limit.

### 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 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 [MarylandABLE.org/forms](https://MarylandABLE.org/forms))
- No**

Want an easier way to enroll?

Go online to [MarylandABLE.org](https://MarylandABLE.org) and use your email to set up an account.

**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

**Residential address**

No PO 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

Are you an Authorized Legal Representative? If so, please complete **Step 3**.  
If not, disregard **Step 3** and move on to **Step 4**.

**3 Authorized Legal Representative information — If applicable**

\*If you are the beneficiary filling out the information on this form. Please skip this section.

\_\_\_\_\_  
**ALR's 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 ABLÉ 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 ABLÉ account for the Beneficiary.

**Legal Guardian**  
The Beneficiary does not have a Power of Attorney pertaining to this ABLÉ account, and I am their legal guardian.

**Conservator**  
The Beneficiary does not have a Power of Attorney pertaining to this ABLÉ account, and I have been appointed conservator.

**Spouse**  
I have the authority to open and manage an ABLÉ account for the Beneficiary.

**Parent**  
I have the authority to open and manage an ABLÉ account for the Beneficiary.

**Sibling**  
I have the authority to open and manage an ABLÉ account for the Beneficiary.

**Grandparent**  
I have the authority to open and manage an ABLÉ account for the Beneficiary.

**Representative Payee**  
I have the authority to open and manage an ABLÉ account for the Beneficiary.

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Please enter ALR's information below

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
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.

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

PO 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

\* 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 ABLÉ 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 <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 ABLÉ 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\(a\)](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 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

**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**:

- |   |  |
|---|--|
| <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              | _____  |
| <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:

\_\_\_\_\_  
 (Please write in all other sources)



**7 Select Investment Option**

There's a \$25 minimum contribution to open an account and you must contribute at least \$5 to each option you want to add money to. You can connect a bank account (**Step 9**) or include a check made out to Maryland ABLE.

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

There are five options to pick from. There are risks involved in investing, your decision should be based on your goals and timeline for this ABLE account. The rest is up to the market's performance.

For an in-depth look at each of the options, please refer to the **Program Disclosure Booklet**.

How do you want to save/invest? (Please select at least one)

**Cash Option**

This fund offers FDIC insurance protection for amounts contributed up to FDIC-permitted limits.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount

**ABLE Fixed Income**

A portfolio of mutual funds intended to produce an overall investment exposure of 100% bonds.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount

**ABLE Conservative**

A portfolio of mutual funds intended to produce an overall investment exposure of approximately 20% stocks and 80% bonds.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount

**ABLE Moderate**

A portfolio of mutual funds intended to produce an overall investment exposure of approximately 50% stocks and 50% bonds.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount

**ABLE Aggressive**

A portfolio of mutual funds intended to produce an overall investment exposure of approximately 84% stocks and 16% bonds.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount

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\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Total contribution amount

The investment options information on this page has been provided by Marquette Associates, the investment advisor for the Maryland ABLE program

**8 Successor Designated Beneficiary information – optional**

This information is needed to confirm the Successor Designated Beneficiary’s eligibility for this ABLE account. The Successor Designated Beneficiary is eligible to inherit the account if the Beneficiary dies or becomes incapacitated. By law, a Successor Designated Beneficiary for an account must be a sibling, step-sibling, or half-sibling of the designated beneficiary, and must also have a qualifying disability.

\_\_\_\_\_  
**Successor Designated Beneficiary 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 Designated Beneficiary?** (Please select one)

I certify under the penalties of perjury that:

- The Successor Designated 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 Successor Designated 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 Successor Designated 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: <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\(a\)](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 Beneficiary 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 Beneficiary’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.

**9 Bank account information**

Attach a voided check or copy of your bank statement showing the name, address, the account number and complete the bank information below. (Please do not staple, use a paper clip for the check).

What type of documentation are you including to verify this bank account?

Voided Check

Bank statement

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:

A000000000 A 0000000000000000 c 1000  
Routing      Account  
Number      Number

**10 Initial Contribution Information**

- Check (Please include a check made out to Maryland ABLE 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  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution  
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see Program Disclosure Booklet for current limits), in addition to the yearly standard contribution limit.\*

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions.

**11 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.

**How do you want to invest?** (Please Select at least one)

Cash Option \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount (per pay period)

ABLE Fixed Income \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount (per pay period)

ABLE Conservative \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount (per pay period)

ABLE Moderate \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount (per pay period)

ABLE Aggressive \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Amount (per pay period)

**Contribution Day (1-28)\*** \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
Total contribution amount  
If you don't pick a date, we'll automatically deduct you contribution on the 1<sup>st</sup> of every month

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

- Standard contribution  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution  
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see Program Disclosure Booklet for current limits), in addition to the yearly standard contribution limit.\*

\* A note on when contributions will be deducted from your bank account: If the Contribution Day you've selected falls on a regular business day, your contribution will be deducted from your bank account two business days prior to the Contribution Day. If the Contribution Day you've selected falls on a weekend or a holiday, the contribution will be deducted from your bank account on the next Business Day.

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions

**12** Verify your identity

**Identification**

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

<p><b>Acceptable ID Documentation</b></p> <p>Option A Include a recent copy of a Department of Motor Vehicles State ID</p> <p>Option B Include a copy of both your Social Security card and your birth certificate</p>
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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.

**13 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 ABLE 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 current limits (see Program Disclosure Booklet for current limits). 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 am seeking to establish an ABLE account as the eligible individual or have been selected by the eligible individual, 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.
- The beneficiary has not obtained a peace or protective order against me.
- I am not subject of a civil or criminal order prohibiting contact with the beneficiary.
- I have not been held civilly or criminally liable for financial exploitation.

\_\_\_\_\_  
**Signature of Beneficiary or Authorized Legal Representative**

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