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)

◯ **No**

Want an easier way to enroll?
Go online to 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 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.

*Continuation from page 3

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 $20 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 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 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).

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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**:

- ◯ Accounting/Auditing
- ◯ Admin/Clerical
- ◯ Art/Antiques Dealer
- ◯ Banking Professional
- ◯ Cannabis related business
- ◯ 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 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

$ __ __ __ , __ __ __ . __ __
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 Beneficary 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 Beneficary 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 Beneficary
  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).

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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 00000000000000 c 1000

Routing Number | Account 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)*
If you don't pick a date, we'll automatically deduct you contribution on the 1st of every month

$ __ __ __ , __ __ __ . __ __
Total contribution amount

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

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 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.

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)