

KY Saves 529 Trusted Contact Person Form (Optional)



- By completing this form, you designate the person identified below as your Trusted Contact Person, and authorize KY Saves 529 and its present and future direct and indirect subsidiaries, affiliates, successors and assigns (Plan) to contact your Trusted Contact Person and disclose information about your Plan account:
 - to address possible financial exploitation;
 - to confirm the specifics of your current contact information, health status, or the identity of any legal guardian, executor, trustee, or holder of a power of attorney; or
 - as otherwise permitted by Financial Industry Regulatory Authority (FINRA) Rules 2165 and 4512.
- **This form does not create or give your Trusted Contact Person a power of attorney. Your Trusted Contact Person will not be able to access your Account or transfer assets to or from your Account.**
- Completion of this form is optional. A Trusted Contact Person must be at least eighteen (18) years of age. You may add, change or remove your Trusted Contact Person online or by using this form.
- Type in your information and print out the completed form, or print clearly, preferably in capital letters and black ink. Mail the form to the address below. Do not staple.

Forms can be downloaded from our website at **kysaves.com** or you can call us to order any form — or request assistance in completing this form — at **1.877.598.7878** Monday through Friday from 8 a.m. to 8 p.m. ET.

1.877.598.7878
Monday to Friday 8 a.m. - 8 p.m. ET

kysaves.com

clientservice@kysaves.com

1.617.559.8939

Regular mailing address:
KY Saves 529
P.O. Box 56014
Boston, MA 02205-6014

Overnight mailing address:
KY Saves 529
95 Wells Ave, Suite 155
Newton, MA 02459

1 Current Account Owner Information

Note: If you have not established an account, also complete and enclose an Enrollment Form.

Account Number *(First nine digits)*

Name of Account Owner *(first, middle initial, last)*

Telephone Number *(In case we have a question about your Account.)*

2 Action for Trusted Contact Person

 Add Remove Change

* KY TRUSTED CONTACT *

3 Trusted Contact Person Information

Name of Trusted Contact Person (*first, middle initial, last*)

Trusted Contact Person's Daytime Telephone Number

Trusted Contact Person's Mobile Telephone Number

Trusted Contact Person's Email Address

Trusted Contact Person's Mailing Address

City

State

Zip Code

Relationship to Account Owner.

Advisor

Attorney

Family Member

Friend

Spouse

Other

4 Signature — YOU MUST SIGN BELOW

By signing below, I hereby certify that:

- I authorize the Plan and its service providers to contact the Trusted Contact Person listed in **Section 3** of this form and/or to take any action indicated in **Section 2** of this form. I authorize the Plan and its service providers to disclose information to the Trusted Contact Person about my Plan Account(s) in the following circumstances: to address possible financial exploitation, to confirm the specifics of my current contact information, health status, or the identity of any legal guardian, executor, trustee or holder of a power of attorney, or as otherwise permitted by FINRA Rule 2165 (*Financial Exploitation of Specified Adults*). I certify that the Trusted Contact Person is at least eighteen (18) years of age.

SIGNATURE

Signature of Account Owner

Date (*mm/dd/yyyy*)