ENable SAVINGS PLAN

Enable Savings Plan
Enrollment Form

IMPORTANT INFORMATION ABOUT OPENING A NEW ACCOUNT.
We are required by federal law to obtain from each person who opens an account certain personal information — including name, street address, and date of birth, among other information — that will be used to verify their identity. If you do not provide us with this information, we will not be able to open your account. If we are unable to verify your identity, we reserve the right to close your account or take other steps we deem reasonable.

- Use this form to open an account.
- An individual can only have one ABLE account nationwide.
- The account can only be opened for an Eligible Individual.
- Before investing, you should check with your home state to determine if it offers tax or other benefits for investing in its own plan.
- You must provide all information except where indicated as optional.
- Type or print clearly, printing in capital letters and black ink. Please mail the form to the Plan. Do not staple.

Forms can be downloaded from our website at **www.EnableSavings.com**, or you can call us to order any form — or request assistance in completing this form — at **1.844.362.2534** any business day from 8 a.m. to 8 p.m. Central Time.

844.ENABLE4 (844.362.2534)
8 a.m. to 8 p.m. Central Time M-F

www.EnableSavings.com

clientservices@EnableSavings.com

Regular mailing address:
Enable Savings Plan
PO Box 219187
Kansas City, MO 64121

Overnight mailing address:
Enable Savings Plan
1001 E 101st Terrace, Suite 200
Kansas City, MO 64131

1. Account type

I am opening an Enable Savings Plan account. *(Please select one of the three.)*

☐ I am opening the account for myself. At a minimum, please complete **Sections 2, 7, 8** and **11** of this form.

☐ I am the Parent or Guardian of the minor Account Owner. At a minimum, please complete **Sections 2, 3, 7, 8** and **11** of this form.

☐ I am opening the account as an Authorized Individual of an eligible Account Owner who either (a) lacks the capacity to contract, or (b) has the legal capacity to contract and has granted me power of attorney. At a minimum, please complete **Sections 1A, 1B, 2, 3, 7, 8,** and **11** of this form.

A. Authorized Indvidual Type. I hereby certify under penalty of perjury that I am: *(select all that apply.)*

☐ 1. Power of Attorney ☐ 2. Conservator ☐ 3. Legal Guardian ☐ 4. Spouse

☐ 5. Parent ☐ 6. Sibling ☐ 7. Grandparent ☐ 8. SSA Appointed Rep Payee

B. ☐ **Required:** I hereby certify under penalty of perjury that I am the above selected Authorized Individual type and any legal documentation that may be provided by me (as applicable) is true and correct. I further certify under penalty of perjury that no other individual who is willing and able to act as Authorized Individual ranks higher on the above list of possible Authorized Individuals; and that I will notify the Program or its designees if my authority expires, is removed, or otherwise changes.

ENABLE SAVINGS ENROLL

2. Account Owner information *(The Account Owner is the Eligible Individual who owns the account.)*

Legal Name *(First name)* *(m.i.)*

Legal Name *(Last name)*

Social Security or Taxpayer Identification Number ***(Required)*** Birth Date *(mm/dd/yyyy)* ***(Required)***

Citizenship *(If other than U.S. citizen, please indicate country of citizenship.)*

Please select the Account Owner's disability, the onset of which occurred prior to their 26th birthday: *(Please check only one. Please talk with your disability advisor with any questions.)*

- ☐ Developmental Disorders *(including Autism)*
- ☐ Intellectual Disability
- ☐ Psychiatric Disorders
- ☐ Nervous Disorders *(including blindness and deafness)*
- ☐ Congenital Anomalies *(including Down Syndrome)*
- ☐ Respiratory Disorders
- ☐ Other

Please select the basis for your eligibility: *(Check only one.)*

- ☐ The Account Owner is eligible to receive Supplemental Security Income benefits.
- ☐ The Account Owner is eligible to receive Social Security Disability benefits.
- ☐ The Account Owner has eligibility established by a disability certification.

Permanent Street Address *(P.O. boxes are **not** acceptable.)*

City State Zip Code

Account Mailing Address if different from above *(This address will be used as the account's address of record for all account mailings if you are opening this account for yourself.)*

City State Zip Code

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

Email Address - ONLY provide if the Account Owner is opening the account for his or herself.

3. Authorized Individual(s) *(If I'm opening the account for myself this section is not required.)*

You must complete this section if you are an Authorized Individual or the Parent or Guardian of a minor Account Owner as indicated in Section 1. The Authorized Individual is the person who can transact on the account on behalf of the Account Owner in accordance with applicable law, court orders (including guardianship or conservator appointments), and any governing documents that apply to the account.

The Authorized Individual's address listed in **Section 3A** will be used as the account's address of record for all account mailings.

If an Authorized Individual's authority to act on behalf of the Account Owner requires the consent and authorization of another person, that person may be added as Co-Authorized Individual in **Section B**. When a Co-Authorized Individual is named, it is the responsibility of the Authorized Individual and the Co-Authorized Individual to manage the Account in accordance with any legal requirements, such as guardianship documents or powers of attorney, that require them to act together. It is the duty of the Authorized Individuals to reach agreement, when necessary, before any action is taken in managing and transacting in the Account. If the Checking Investment Option is selected, only the Authorized Individual named in **Section A** will be authorized to write checks and use the debit card. The Plan reserves the right to require the Authorized Individuals to submit a Co-Guardian Release Form if the Checking Investment Option is selected and the Authorized Individual and the Co-Authorized Individual are required to act together.

A. **Authorized Individual**

Authorized Individual's First Name (m.i.)

Authorized Individual's Last Name

Social Security or Taxpayer Identification Number ***(Required)*** Birth Date (mm/dd/yyyy) ***(Required)***

Citizenship (If other than U.S. citizen, please indicate country of citizenship.)

☐ Check if address is the same as Account Owner, otherwise complete the following:

Permanent Street Address (P.O. boxes are not acceptable.)

City State Zip Code

Account Mailing Address if different from above (This address will be used as the account's address of record for all account mailings.)

City State Zip Code

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

Email Address

B. **Co-Authorized Individual** (Only if applicable – provide information for a co-guardian or co-conservator appointed in the guardian or conservator document.)

It is the responsibility of the Authorized Individual named in Section A and the Co-Authorized Individual named below to manage the Account in accordance with any legal requirements, such as guardianship documents or powers of attorney, that require them to act together. It is the duty of the Authorized Individuals to reach agreement, when necessary, before any action is taken in managing and transacting in the Account. If the Checking Investment Option is selected, only the Authorized Individual named in Section A will be authorized to write checks and use the debit card. The Plan reserves the right to require the Authorized Individuals to submit a Co-Guardian Release Form when the Checking Investment Option is selected and the Authorized Individual and the Co-Authorized Individual are required to act together.

Co-Authorized Individual's First Name (m.i.)

Co-Authorized Individual's Last Name

Social Security or Taxpayer Identification Number ***(Required)*** Birth Date (mm/dd/yyyy) ***(Required)***

Citizenship (If other than U.S. citizen, please indicate country of citizenship.)

☐ Check if address is the same as Account Owner, otherwise complete the following:

Permanent Street Address (P.O. boxes are not acceptable.)

City State Zip Code

Account Mailing Address if different from above (This address will be used as the account's address of record for all account mailings.)

City State Zip Code

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

Email Address

A. **Co-Authorized Indvidual Type.** I hereby certify under penalty of perjury that I am: (select all that apply.)

☐ 1. Power of Attorney ☐ 2. Conservator ☐ 3. Legal Guardian ☐ 4. Spouse

☐ 5. Parent ☐ 6. Sibling ☐ 7. Grandparent ☐ 8. SSA Appointed Rep Payee

B. ☐ **Required:** I hereby certify under penalty of perjury that I am the above selected Authorized Individual type and any legal documentation that may be provided by me (as applicable) is true and correct. I further certify under penalty of perjury that no other individual who is willing and able to act as Authorized Individual ranks higher on the above list of possible Authorized Individuals; and that I will notify the Program or its designees if my authority expires, is removed, or otherwise changes.

4. Interested party information *(Optional)*

Complete this section if you want to add an individual as an interested party to the account. An interested party will be able to call the Plan, receive information verbally about the account and receive quarterly statements. An interested party will not be allowed to make changes to the account or request transactions.

Name

Mailing Address

City State Zip Code

Telephone Number

Relationship to Account Owner.

☐ Compliance ☐ Family Member ☐ Other

5. Successor Account Owner *("SAO")* Information *(optional)*

- As the Account Owner, you may designate a SAO to take control of the account in the event of your death.
- The person you designate as SAO must be an Eligible Individual and at least 18 years old.
- The SAO designation must be submitted and processed while the Account Owner is living.
- An account transfer to an SAO is not treated as a distribution if the new Account owner is an Eligible Individual and a Member of the Family of the Account Owner. If the new Account Owner is **not** an Eligible Individual **and** a Member of the Family of the Account Owner, the transfer is treated as a Non-Qualified Withdrawal
- A Death Certificate for the Account Owner and other documentation will be required before the account is transferred to the SAO.

Legal Name *(First name)* /or Trust Name *(m.i.)*

Legal Name *(Last name)* /or remaining Trust Name

Birth Date or Trust Date *(mm/dd/yyyy)*

6. $5k or less Inheritor Information *(Optional)*

- In the event an Account has designated both a SAO and a $5k or less Inheritor, the SAO designation will take precedence.
- As the Account Owner, you may designate a $5k or less Inheritor to receive the assets in your account in the event of your death.
- Account assets must be $5,000 or less at the time of the Account Owner's death.
- The person you designate as the $5k or less Inheritor must be at least 18 years old.
- A personal representative of the Account Owner's estate can make the $5k or less Inheritor designation (if no SAO or $5k or less Inheritor is on file).
- The $5k or less Inheritor distribution will be considered a Non-Qualified Withdrawal. A Form 1099-QA will be issued to the Account Owner.
- A Death Certificate for the Account Owner and other documentation will be required before the distribution is made to the $5k or less Inheritor.

Legal Name *(First name)* /or Trust Name *(m.i.)*

Legal Name *(Last name)* /or remaining Trust Name

Birth Date or Trust Date *(mm/dd/yyyy)*

7. Investment Option selection

- Before choosing your Investment Option(s), please read the Program Disclosure Statement, *available at* **www.EnableSavings.com** for complete information.
- Please select one or more Investment Options from the choices below. If you choose one Investment Option please indicate 100% next to that option. If you choose more than one Investment Option please indicate the percentage amount of the contribution you would like invested into each of the selected Investment Options.
- Use whole percentages only.
- Your total Investment Option percentages must equal **100%.**

Growth Option	☐☐☐ %
Moderate Option	☐☐☐ %
Conservative Option	☐☐☐ %
Bank Savings Option	☐☐☐ %
*Checking Option	☐☐☐ %
Total	**1 0 0 %**

If Authorized Individuals are named in **Section 3A and 3B** and are required to act together, it is the duty of those Authorized Individuals to reach agreement, when necessary, before any action is taken in managing and transacting in the Account. If the Checking Investment Option is selected, only the Authorized Individual named in **Section 3A** will be authorized to write checks and use the debit card. The Plan reserves the right to require the Authorized Individuals to submit a Co-Guardian Release Form if the Checking Investment Option is selected and the Authorized Individual and the Co-Authorized Individual are required to act together.
*If you did not select the Checking Option please skip to **Section 8** now. If you selected the Checking Option please continue here and provide the information requested below:*

***Important Information about the Checking Option:**

- You will receive the Terms and Conditions, *The ENABLE Savings Plan Checking Investment Option Pricing and Services at a Glance*, of your checking account within 7-10 business days of account funding. These disclosures govern all aspects of this account. We recommend you retain a copy of the disclosures for your records.
- Account Owner information must be completed in **Section 7A**.
- If the Account Owner is a minor or if there is an Authorized Individual on the account, please also complete **Section 7B**.

☐ *(optional)* Please send a debit card with the Checking Option. The Account Owner or Authorized Individual (depending on Account type) will receive a free debit card within 10 days after the Checking Option is funded.

☐ *(optional)* Please send me a Starter Pack Checkbook. A fee of $6.00 will be deducted from the Checking Investment Option. The check book will be shipped when the balance of the Checking Option is at least $25.00.

*Information in **Sections 7A** and **7B** is required to help the government prevent the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who selects the Checking Option. This means at the time you select the Checking Option we will ask for your name, address, date of birth, and other information that will allow us to identify you.*

A. **Account Owner's identity verification.** *All the fields require a response.*

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐ – ☐☐ – ☐☐☐☐

Account Owner's driver's license or state-issued I.D. card number *(7-15 digits)* | State | Expiration date *(mm/dd/yyyy)*

Is this a driver's license or state-issued I.D. card? Please check one: ☐ Driver's license ☐ I.D. card

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Account Owner's mother's maiden name

B. **Authorized Individual identity verification.** *(Only if applicable - enter information about person named in* ***Section 3A****)*
All the fields require a response.

Responsible Individual's driver's license or state-issued I.D. card number *(7-15 digits)* State Expiration date *(mm/dd/yyyy)*

Is this a driver's license or state-issued I.D. card? Please check one: ☐ Driver's license ☐ I.D. card

Responsible Individual's mother's maiden name

8. Contribution Method

- Your initial contribution can come from several sources combined, but you must check at least one source. If you combine sources, check the appropriate box for each source and write in the contribution amount for each.
- Contributions by any source will not be available to withdraw for 5 business days. For contributions to the Checking Investment Option, the contribution will not be made available for withdrawal for 6 business days.
- There is a minimum initial contribution of $50 to enroll in an Enable Savings Plan account. However, the minimum initial contribution is $25 if you set up an Automatic Investment Plan or Payroll Deduction when you enroll.

Source of funds *(Check all that apply.)*

A. ☐ **Automatic Investment Plan (AIP).** You can have a set amount automatically transferred from a bank, savings and loan, or credit union account monthly or quarterly, or you can choose the months in which you would like your AIP to occur. Money will be transferred into your Enable Savings Plan account electronically based on the frequency indicated below. You may change the amount and/or frequency at any time by logging into your account at **www.EnableSavings.com** or by calling **1.844.362.2534.** Account Owners, family members, and friends can all contribute to an Enable Savings Plan account through AIP. To add additional AIP instructions or multiple bank accounts, attach a separate sheet with the information requested in **Sections 8B** and **9** for each additional AIP instruction or bank account.

Important: To set up this option, you must provide bank information in **Section 9.**

☐ **Annual Increase.** You may increase your AIP contribution automatically on an annual basis. Your contribution will be adjusted each year in the month that you specify by the amount indicated.

Amount of increase: $ __ , __ __ __ . 0 0

Month:**

** The month in which your AIP contribution will be increased. The first increase will occur at the first instance of the month selected.

Amount of Debit: ☐ $25 ☐ $50 ☐ $100 ☐ $150 ☐ Other $ __ , __ __ __ . 0 0
Amount

Frequency *(Check One)*: ☐ Monthly ☐ Quarterly (Every three months.) **OR** ☐ Custom (Check the months below that you would like your AIP to occur.)

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

Day of Month:*

*The Enable Savings Plan must receive instructions at least 3 business days prior to the day of the month specified; otherwise, debits from a bank account will begin the following month on the day specified. Please review your quarterly statements for details of these transactions. If the date is not specified, this AIP option will begin the month following the receipt of this request, on the 10th day of the month.

B. ☐ **Check.**
Important: All checks must be payable to the **Enable Savings Plan.**

$ __ __ , __ __ __ . 0 0
Amount

C. ☐ **Payroll Direct Deposit.** If you want to make contributions to your Enable Savings Plan account directly from a paycheck, you must contact your employer's payroll office to verify that you can participate. Payroll Direct Deposit contributions will not be made to your account until you have received a **Payroll Direct Deposit Confirmation Form** from the Enable Savings Plan, provided your signature, and your Social Security or taxpayer identification number on the form, and submitted the form to your employer's payroll office.

- Please note that the dollar amount indicated below need only be an estimate of your intended deposit. You may work with your employer's payroll office to deposit more or less for any given pay period.

Approximate amount of Payroll Direct Deposit each pay period: **$** ☐,☐☐☐.**0 0**

D. ☐ **Electronic Fund Transfer (EFT).** Through EFT, you can make contributions online or by phone whenever you want by transferring money from a bank account. We will keep the bank instructions on file for future EFT contributions. To set this up, you must provide bank information in **Section 7.** The Plan may place a limit on the total dollar amount per day you may contribute to an account by EFT. *(The amount below will be a one-time EFT contribution to open your account.)*

$ ☐☐,☐☐☐.☐☐
Amount

E. ☐ **Rollover from another state's qualified ABLE program to the Enable Savings Plan.** Complete and include an **Incoming Rollover Form**, available online at **www.EnableSavings.com,** or by calling **1.844.362.2534. By law, rollovers between qualified ABLE plans for the same Account Owner are permitted only once every 12 months.**

$ ☐☐☐,☐☐☐.**0 0**
Amount

9. Bank Information. Required to establish the AIP or EFT service.

AIP and EFT contributions can be made only through accounts held by a U.S. bank, savings and loan association, or credit union that is a member of the Automated Clearing House (ACH) network. Money market mutual funds and cash management accounts offered through non-bank financial companies cannot be used.

Important: By signing this Enrollment Form, you agree and confirm that your ACH transactions will not involve the branches or offices of a bank or other financial services company located outside the territorial jurisdiction of the United States.

Bank Name

☐☐☐☐☐☐☐☐☐ Bank Routing Number

☐☐☐☐☐☐☐☐☐☐☐ Bank Account Number

Account Type: *(Check One)* ☐ Checking ☐ Savings

Names on Bank Account, Savings and Loan or Credit Union

Name *(first, middle initial, last)*

Name *(first, middle initial, last)*

If you are not the bank account owner, the named bank account owner(s) must authorize the use of their bank account for this AIP and/or EFT service by signing here.

SIGNATURE
Signature

☐☐ — ☐☐ — ☐☐☐☐
Date *(mm/dd/yyyy)*

SIGNATURE
Signature

☐☐ — ☐☐ — ☐☐☐☐
Date *(mm/dd/yyyy)*

10. Systematic Exchange Program *(Optional)*

The Systematic Exchange Program allows you to move money from one Investment Option to one or more other Investment Options within your account on a pre-scheduled basis.

- To start a Systematic Exchange Program you must designate a minimum total amount of $500 to be exchanged from one Investment Option to one or more other Investment Options on a pre-scheduled basis. The Exchange From Investment Option section must have a minimum of $500 in assets to start the Systematic Exchange Program.
- Your entire initial deposit does not need to be included in the Systematic Exchange Program.
- You must designate a minimum of $50 for each monthly or quarterly scheduled exchange.
- Creating a Systematic Exchange at the time of enrollment will NOT count towards your twice per calendar year investment change limit. To start a Systematic Exchange at the time of enrollment you must mail a contribution check with this completed form to the Plan.
- If you make any changes to or cancel an established Systemic Exchange Program it will count towards your twice per calendar year investment change limit.
- If you are selecting the Checking Option as an "Exchange To Investment Option" you must also complete the identity verification information in **Sections 7A** and **7B** *(if applicable)*.

Frequency *(Check One)*: ☐ Monthly ☐ Quarterly *(3 months from the start date)*

Day of Month:* ☐☐

*The first systematic exchange will occur on the day of the month indicated above if received within 3 business days of that date; otherwise, the systematic exchange will begin the following month. If a date is not specified, the exchange will take place on the 10th day of the month.

Exchange From Investment Option: _____

Exchange To Investment Option per Exchange Period:

_____ Investment Option — $ ☐,☐☐☐.00 Dollar Amount *($50 Minimum)*

_____ Investment Option — $ ☐,☐☐☐.00 Dollar Amount *($50 Minimum)*

_____ Investment Option — $ ☐,☐☐☐.00 Dollar Amount *($50 Minimum)*

Stop Type *(Select one)*:

☐ **Stop Date:** ☐☐ – ☐☐ – ☐☐☐☐ Date *(mm/dd/yyyy)*

☐ **When total amount of Exchanges equal:** $ ☐☐,☐☐☐.00

☐ **When Complete Balance of the "Exchange From" Investment Option is depleted**

By completing this section and signing this form, I authorize the Enable Savings Plan to process the periodic exchanges as indicated. I understand that making changes to an established Systematic Exchange Program will count towards my twice per calendar year investment option change limit.

11. Signature — YOU MUST SIGN BELOW

- By signing below, I hereby acknowledge that I have received, read, and that by signing this form, agree to the terms and conditions of the Program Disclosure Statement and the Enable Savings Plan Checking Investment Option Pricing and Services at a Glance, which govern all aspects of this account and are incorporated herein by reference. I will retain copies of the Program Disclosure Statement and the Pricing and Services at a Glance for my records.
- I certify under penalty of perjury that all of the information I have provided on this form is accurate and complete, including without limitation, the information regarding the Account Owner's disability and the Account Owner's status as an Eligible Individual. I certify, under penalty of perjury that I will promptly notify the Program Manager or its designee if changes in the Account Owner's condition would result in the Account Owner no longer qualifying as an Eligible Individual. I acknowledge and agree that I am bound by the terms, rights and responsibilities stated in the Program Disclosure Statement and this form, and by any and all statutory, administrative and operating procedures that govern the Enable Savings Plan. I understand that the Program Disclosure Statement, Enrollment Form and any subsequent forms signed by me constitute the entire agreement between me and The Nebraska Achieving a Better Life Experience Program Trust ("Trust"). No person is authorized to make an oral modification to this agreement.
- If the Account Owner is an Eligible Individual based on certification eligibility, I certify under penalty of perjury that the Account Owner (1) has a medically determinable physical or mental impairment, which results in marked or severe functional limitations, and which (i) can be expected to result in death or (ii) has lasted or can be expected to last for a continuous period of not less than 12 months; or (2) is blind (within the meaning of section 1614(a)(2) of the Social Security Act) and that such blindness or disability occurred before the date on which the individual attained age 26. I further certify under penalty of perjury that I have obtained and will continue to retain a copy of the written diagnosis of the Account Owner's blindness or disability, signed by a doctor of medicine (MD) or doctor of osteopathy (DO) legally authorized to practice medicine and surgery by the state in which the diagnosis is made, and includes the name and address of the diagnosing doctor and the date of the diagnosis and to provide a copy of the written diagnosis to the Program Manager or its designee, the IRS, or the U.S. Treasury Department if requested.
- If the Account Owner is an Eligible Individual based on Supplemental Security Income benefits or Social Security Disability benefits, I certify under penalty of perjury that the Account Owner: (1) is entitled to benefits under Title II or XVI of the Social Security Act based on blindness or disability; (2) has received a benefit verification letter from the Social Security Administration; and (3) agrees to retain and provide the letter (or a genuine copy of the letter or other evidence) the Program Manager or its designee, the IRS, or the U.S. Treasury Department if requested.
- I understand investments are not guaranteed or insured by the FDIC (except for the Bank Savings Investment Option and the Checking Investment Option) or any other government agency, and are not deposits or other obligations of any depository institution. Investments are not guaranteed or insured by the Enable Savings Plan, the Trust, the State of Nebraska, the Nebraska State Treasurer, the Nebraska Investment Council, or any of their authorized agents or affiliates, (collectively, "Enable Associated Persons") and are subject to investment risks including the loss of the principal amount invested.
- I understand that participation in the Enable Savings Plan does not guarantee that contributions and the investment return on contributions, if any, will be adequate to cover the Qualified Disability Expenses of the Account Owner.
- I intend to use the Account solely to pay Qualified Disability Expenses.
- If I am selecting the Checking Investment Option I hereby acknowledge that I have received, read, and that by signing this form, agree to the Checking Investment Option Terms and Conditions (The Enable Savings Plan Checking Investment Option Pricing and Services at a Glance).
- If I am rolling over assets from another qualified ABLE program, by signing below I certify under penalty of perjury that there has not been a rollover for the benefit of the Account Owner during the prior 12-month period. I further understand that moving assets among investment options within the Enable Plan will count towards my permitted twice per calendar year Investment Option change limit.
- If I have chosen the AIP or EFT option, I authorize the Program Manager and its designees, upon telephone or online request, to pay amounts representing redemptions made by me or to secure payment of amounts invested by me, by initiating credit or debit entries to my account at the bank named in **Section 9**. I authorize the bank to accept any such credits or debits to my account without responsibility to their correctness. I acknowledge that the origination of ACH transactions involving my bank account must comply with U.S. law. I further agree that the Enable Associated Persons will not incur any loss, liability, cost, or expense for acting upon my telephone or online request. I understand that this authorization may be terminated by me at any time by notifying the Program Manager or its designee and the bank by telephone or in writing, and that the termination request will be effective as soon as the Program Manager or its designee and the bank have had a reasonable amount of time to act upon it. I certify that I have authority to transact on the bank account identified by me in **Section 7** or that the account owners of such bank account have authorized me to institute this AIP and/or EFT service from their account on their behalf.

Signature *(cont.)*

- To the best of my knowledge, each contribution to my account will not cause (i) the annual contributions in the account to exceed the Annual Contribution Limit or (ii) the balance in the account to exceed the Account Balance Limit then in effect.
- If the Account Owner is a minor, I certify that under penalty of perjury I am of legal age in my state of residence, I am the parent, guardian or Authorized Individual of the account, I am authorized to open the account, I am not aware of any adverse claim of ownership or court order relating to this account, and I agree to hold harmless the Enable Associated Persons from any third party claims relating to my actions.
- If I am an Authorized Individual, I hereby certify under penalty of perjury that (1) I am authorized as the agent of the Account Owner named in **Section 2** under a power of attorney or, if none, a conservator or legal guardian, spouse, parent, sibling, grandparent of the Account Owner, or a representative payee appointed for the Account Owner by the Social Security Administration with the authority to establish and manage the account; (2) that no other individual who is willing and able to act as Authorized Individual ranks higher on the prioritized list of possible Authorized Individuals and (3) I will notify the Program Manager or its designee if my authority expires, is removed, or otherwise changes. I agree to hold harmless the Enable Associated Persons from any third party claims relating to my actions.
- If I am an Authorized Individual, I hereby certify that each time I make a withdrawal from the ABLE program account that the withdrawal is duly authorized under all applicable law, court orders, and any other governing documents that apply to the account, and that the withdrawal is for the benefit of the Account Owner and not solely for my own personal benefit or solely for the benefit of a third person.
- I certify under penalty of perjury that no other qualified ABLE program account exists for the benefit of the Account Owner, except in the case of a rollover from another qualified ABLE program. If I am establishing this account through a rollover from an account in another qualified ABLE program, I agree to close the other account no later than the 60th day after the amount was distributed from the other qualified ABLE program account. I acknowledge that failure to do so will result in my account not being treated as a qualified ABLE program account. The consequences of an account not being treated as a qualified ABLE program account include loss of favorable tax treatment and could lead to loss of eligibility for resource-based benefits such as SSI. If I am rolling over assets from another qualified ABLE program, I further certify under penalty of perjury that there has not been a rollover for the benefit of the Account Owner during the prior 12-month period.
- I agree to promptly inform the Program Manager or its designee in the event that any of the foregoing certifications becomes untrue. I understand and acknowledge that the Program Manager or its designee has the right to suspend or terminate the account and return the balance of the account (which withdrawal may be a Non-Qualified withdrawal) to the Account Owner, as applicable, if the Program Manager or its designee has reasonable grounds to believe that any of the foregoing certifications is untrue.
- If you have a guardian or conservator to manage or protect your assets, by signing below you are certifying that you have worked with that person before opening this account.
- If the Account Owner is an employed Account Owner and intends to make additional compensation contributions above the annual maximum contribution limit ($18,000 as of 2024), I certify under penalty of perjury that (1) the Account Owner is employed, (2) the Account Owner has neither made nor received contributions to a 401(k), 403(b), or 457(b) plan in the same calendar year as the compensation contributions, and (3) the Account Owner's contributions of compensation are not excess compensation contributions as described in the Program Disclosure Statement.

SIGNATURE

Signature of Account Owner *(or Responsible Person listed in **Section 3A**)*

☐☐ – ☐☐ – ☐☐☐☐

Date *(mm/dd/yyyy)*

SIGNATURE

Signature of co-guardian or co-conservator listed in **Section 3B** *(Only if applicable)*

☐☐ – ☐☐ – ☐☐☐☐

Date *(mm/dd/yyyy)*

12. Additional Information *(Optional)*

How did you hear about the Enable Savings Plan? *(Select One.)*

- ☐ Family/Friend
- ☐ Organization
- ☐ Employer
- ☐ School Event
- ☐ Enable Website
- ☐ Treasurer's Website
- ☐ Advisor
- ☐ Ad
- ☐ Email
- ☐ Magazine
- ☐ Mailing
- ☐ Other