

## State Farm® 529 Savings Plan

## **Organization Resolution Form**

- This form identifies the officers or other persons who are authorized to conduct transactions on State Farm 529 Savings Plan (State Farm Plan) Account(s) on behalf of an organization.
- Complete a separate form for each Account Owner for whom the organization serves as an agent.
- Organizations covered by this form include: corporations; partnerships; limited liability companies or partnerships; professional corporations or associations; endowments; business trusts; and other entities or organizations.
- This form requires the signature of two authorized persons from your organization, one of whom must be the secretary or other authorized person who can certify the names of those authorized to access and transact on a State Farm Plan Account. If your organization has only one authorized signatory, then a bank officer, practicing attorney or member of a domestic stock exchange must countersign this form.
- This resolution remains in effect until we have been notified in writing that it has been revoked or a new **Organization Resolution Form** has been submitted. You must file a new **Organization Resolution Form** when there is any change in the identity of the persons authorized to act on behalf of your organization.
- Print clearly, preferably in capital letters and black ink. Mail the form to the address listed. Do not staple.

Forms can be downloaded from our website at **www.statefarm.com**, or you can call us to order any form—or request assistance in completing this form—at **1.800.321.7520** any business day from 8 a.m. to 8 p.m. Central time.

	1.800.321.7520	
<b>       </b>	<b>1.800.321.7520</b> 8 a.m. to 8 p.m. Central Time M-F	•

www.statefarm.com

Regular mailing address: **State Farm 529 Savings Plan P.O. Box 419096 Kansas City, MO 64141-9096** 

Overnight mailing address: State Farm 529 Savings Plan 920 Main Street, Suite 900 Kansas City, MO 64105

## 1. Organization information

Name of Organization							
Address							
City				State	Zip Code		
Firm Tax ID Number							



## **2. Agent for the State Farm Plan Account Owner** (Complete only if the organization is acting as agent for the State Farm Plan Account Owner.)

Α.	Account Owner information (Do not include agent information here; provide as indicated in Section 2B.)
	Name (first, middle initial, last)
	Mailing Address
	City State Zip Code
	Social Security Number or Taxpayer Identification Number <i>(Required)</i>
В.	Agent's authorized persons
	• Any one of the persons listed in this <b>Section 2B</b> is authorized to act on behalf of the organization, pursuant to the organization's authority as an agent in accordance with an <b>Agent Authorization/Limited Power of Attorney Form</b> filed with the State Farm Plan previously or at the same time as this form, with respect to the Account Owner identified in <b>Section 2A</b> .
	• The organization acknowledges that the persons identified in this <b>Section 2B</b> are authorized to act only with respect to the specified State Farm Plan Accounts owned by the Account Owner identified in <b>Section 2A</b> on which the organization has been authorized as an agent. The organization further acknowledges that it must file separate Organization Resolutions for each additional Account Owner for whom the organization serves as an agent.
	• The organization acknowledges that it is solely responsible for informing the State Farm Plan of any changes in the authority or identity of the persons listed in this <b>Section 2B</b> , and that the State Farm Plan or its agents are not responsible for any acts or failure to act taken in regard to any instructions believed to have originated from any person identified in this <b>Section 2B</b> until the State Farm Plan has received written notice of the revocation of such person's authority or receives a new Organization Resolution Form and the State Farm Plan has had a reasonable period of time to act upon such notice. Each Organization Resolution filed with the State Farm Plan revokes any Organization Resolution previously filed with the State Farm Plan in its entirety.
	• If the organization has more Authorized Persons than can be completed in the space below, please include a separate sheet that provides the name and title of each Authorized Person.
	Name(s) of Agent's Authorized Persons
	Name of Authorized Person (first, middle initial, last) and Title
	Name of Authorized Person (first, middle initial, last) and Title
	Name of Authorized Person (first, middle initial, last) and Title
	Name of Authorized Parage (first middle initial leatland Title
	Name of Authorized Person (first, middle initial, last) and Title

Name of Authorized Person (first, middle initial, last) and Title

We, and	(names), duly authorized officers of the
organization identified in <b>Section 1,</b> hereby certify the following:	. ,
That each of the authorized persons listed in <b>Section 2B</b> is authorized to account owner identified in <b>Section 2A</b> .	
The organization agrees to indemnify and hold harmless, the State Farm Plathe State of Nebraska, the Nebraska State Treasurer, the Nebraska Investme Program Manager and its authorized agents, and any of their respective affixed persons, individually, a "third party") from and against all losses, claim incurred by any of them for relying in good faith upon information provided by a third party to have originated from any authorized person identified in a effect until revoked by an authorized signatory of the organization. Each <b>Or</b> Plan or its agents revokes an <b>Organization Resolution Form</b> previously fill Any revocation will not affect any liability resulting from transactions initial amount of time to act upon the revocation.	nent Council, State Farm VP Management Corp., the filiates, agents, and employees acting hereunder (any cons, and expenses (including attorney's fees) of any kind in this resolution and for acting on instructions believe <b>Section 2B.</b> This resolution remains in full force and <b>rganization Resolution Form</b> filed with the State Farmeled with
We are authorized and directed to certify the above and confirm that these document of our organization.	provisions conform to the charter or other organizing
Signature — YOU MUST SIGN BELOW	
I certify that I have read and understand, consent, and agree to all the terms ar Statement and Participation Agreement (Program Disclosure Statement).	nd conditions of the State Farm Plan Program Disclosu
SIGNATURE	
Name of Authorized Signatory	Date (mm/dd/yyyy)
Name of Authorized Signatory	Date (mm/dd/yyyy)
Name of Authorized Signatory  Title	Date (mm/dd/yyyy)
Title	Date (mm/dd/yyyyy)
Title	
Title	Date (mm/dd/yyyy)  Date (mm/dd/yyyy)
Title	
Title	
Title  SIGNATURE  Name of Authorized Signatory  Title	Date (mm/dd/yyyy)
Title  SIGNATURE  Name of Authorized Signatory  Title	Date (mm/dd/yyyy)  authorized signatory
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one	Date (mm/dd/yyyy)  authorized signatory
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one I certify that the person who signed above is the duly authorized signatory of the SIGNATURE	Date (mm/dd/yyyy)  authorized signatory
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one I certify that the person who signed above is the duly authorized signatory of the signature of the s	Date (mm/dd/yyyy)  authorized signatory he organization identified in Section 1.
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one I certify that the person who signed above is the duly authorized signatory of the SIGNATURE  Signature of Bank Officer, Practicing Attorney, or Member of a Domestic Stock Exchange	Date (mm/dd/yyyy)  authorized signatory he organization identified in Section 1.  Date (mm/dd/yyyy)
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one I certify that the person who signed above is the duly authorized signatory of the SIGNATURE	Date (mm/dd/yyyy)  authorized signatory he organization identified in Section 1.  Date (mm/dd/yyyy)
Title  SIGNATURE  Name of Authorized Signatory  Title  Third Party Certification — Required if your organization has only one I certify that the person who signed above is the duly authorized signatory of the signature of Bank Officer, Practicing Attorney, or Member of a Domestic Stock Exchange	Date (mm/dd/yyyy)  authorized signatory he organization identified in Section 1.  Date (mm/dd/yyyy)

**StateFarm**®

First National Capital Markets and First National Bank of Omaha are affiliates.

First National Bank Omaha

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