KANSAS ABLE SAVINGS PLAN

KS ABLE

Entity Verification and Signatory Form

INSTRUCTIONS:

- **Entity Verification and Signatory Form** ("Form") allows a company, organization - either for-profit or non-profit, – or government agency that is designated to act as Authorized Individual for one or more ABLE Eligible Individuals ("Entity"), to provide the information needed by the Plan to verify the identity of the Entity, the Control Person and/or Beneficial Owner(s). In addition, the Form permits the Control Person to delegate representative(s) to act on behalf of the Entity and to bind the Entity with respect to Kansas ABLE Savings Plan Accounts opened or maintained by the Entity (each a "Signatory" or collectively "Signatories"). Signatories have the authority to open, manage, and view Accounts under the Entity's authority.
- This Form must be completed and signed by an individual with significant responsibility to control, manage, or direct the Entity, which may include, but is not limited to, the: Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Managing Member, General Partner, President, Vice President, Treasurer, Executive Director/Director of a government agency, or any other individual who regularly performs similar functions ("Control Person"). Please see 31 C.F.R. § 1010.230(d)(2). The Control Person must have the authority to make binding commitments on behalf of the Entity.
  - For-profit entities must complete **Sections 1, 2** and **3**.
  - Non-profit entities must complete **Sections 1** and **3**.
  - Government agencies must complete **Sections 1** and **3**.
- The Control Person must designate at least one other Signatory other than themselves to act on behalf of the Entity for the purposes of opening and managing Kansas ABLE Accounts for Eligible Individuals served by the Entity.
- A completed, signed and notarized Form must be submitted by regular mail, overnight carrier, or fax to Kansas ABLE Savings prior to opening any Accounts; the Form will be held on file in a secure manner by Kansas ABLE Savings. If you have any questions completing the Form, please contact Kansas ABLE Savings at **888-609-8919**.
- Capitalized terms used in this Form, but not defined in this Form, have the meanings provided in the Plan Disclosure Booklet.
- To add additional Signatories, please attach a separate, typewritten page with individual names, titles, direct phone numbers, and signatures.
- The Entity is responsible for immediately submitting a new Form each time any information on the Form changes or needs to be updated.
- The email address provided must be a continually monitored organizational email address that is not associated with a specific employee and to which all Signatories have access.

1.888.609.8919
8 a.m. to 5 p.m. CT M-F

FAX 1.617.559.8921

ks.savewithable.com

ks.clientservice@savewithable.com

Regular mailing address:
Kansas ABLE Savings Plan
P.O. Box 219266
Kansas City, MO 64121

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

1. Required Information For All Entities

Entity Information

Entity Name

Entity Type (for-profit, non-profit or government agency)

Entity Mailing Address

City | State | Zip Code

Entity Tax ID

Entity Direct Telephone Number

Control Person (This information is collected for identity verification in compliance with federal law).

Control Person's Legal First Name | M.I.

Control Person's Legal Last Name

Control Person's Title

Control Person's Residential Address

City | State | Zip Code

Control Person's Birth Date (mm/dd/yyyy)

Control Person's Social Security Number

Control Person's Direct Telephone Number

Signatories Note: The Control Person(s) always has signature authority and does not need to be separately listed in this section.

Signatory's Legal First Name — M.I.

Signatory's Legal Last Name

Signatory's Title

Signatory's Direct Telephone Number

SIGNATURE

Signature of Signatory — Date (mm/dd/yyyy)

Signatory's Legal First Name — M.I.

Signatory's Legal Last Name

Signatory's Title

Signatory's Direct Telephone Number

SIGNATURE

Signature of Signatory — Date (mm/dd/yyyy)

Signatory's Legal First Name — M.I.

Signatory's Legal Last Name

Signatory's Title

Signatory's Direct Telephone Number

SIGNATURE

Signature of Signatory — Date (mm/dd/yyyy)

Signatory's Legal First Name — M.I.

Signatory's Legal Last Name

Signatory's Title

Signatory's Direct Telephone Number

SIGNATURE

Signature of Signatory — Date (mm/dd/yyyy)

2. Additional Required Information For For-Profit Entities

For-profit Entities are required to identify any individual who directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise, owns 25% or more of the equity interests of the legal Entity ("Beneficial Owner"). Please see 31 C.F.R. § 1010.230(d)(1).

Use the space below and on the next page to identify Beneficial Owners, other than the Control Person, if any. If additional space is needed to identify Beneficial Owners, please attach a separate, typewritten page with Entity name, Entity Tax ID, Beneficial Owner(s) first and last name(s), title(s), residential address(es), birth date(s), SSN(s) and telephone number(s).

To protect personally identifiable information, a Beneficial Owner may opt to complete this page separately and mail the completed page to the address on page 1 of this Form.

Beneficial Owner #1

Entity Name

Entity Tax ID

Beneficial Owner #1's First Name M.I.

Beneficial Owner #1's Last Name

Beneficial Owner #1's Title

Beneficial Owner #1's Residential Address

City State Zip Code

Beneficial Owner #1's Birth Date (mm/dd/yyyy)

Beneficial Owner #1's Social Security Number

Beneficial Owner #1's Telephone Number

Beneficial Owner #2

Entity Name

Entity Tax ID

Beneficial Owner #2's Legal First Name M.I.

Beneficial Owner #2's Legal Last Name

Beneficial Owner #2's Title

Beneficial Owner #2's Residential Address

City State Zip Code

Beneficial Owner #2's Birth Date (mm/dd/yyyy)

Beneficial Owner #2's Social Security Number

Beneficial Owner #2's Telephone Number

3. Control Person Certifications – Required for all Entities:

I,_____, (full name) certify that I am the Control Person of the Entity named in **Section 1** of this Form, and I am duly authorized to act on the Entity's behalf. As such, I certify the truth and accuracy of the following.

1. I have the authority to execute this Form on behalf of the Entity and have the authority to bind the Entity.
2. I have familiarity with the business and affairs of the Entity so as to be able to knowledgably make the statements set forth in this Form.
3. The Entity is in good standing in its jurisdiction of formation and other required jurisdictions.
4. I understand that Kansas ABLE Savings Plan will, in part, rely on the statements set forth on this Form in determining whether the Entity will be permitted to open Kansas ABLE Savings Plan Accounts on behalf of Eligible Individuals.
5. I have the authority to: (i) act on behalf of the Entity; and (ii) delegate authority to the Signatories named on this Form to further act on behalf of the Entity and to bind the Entity with respect to any Kansas ABLE Savings Plan Account established or maintained by the Entity for an Eligible Individual.
6. I authorize the Kansas ABLE Savings Plan and the Kansas ABLE Savings Plan Plan Administrators: (i) to recognize the authority delegated to each Signatory named on this Form; (ii) to accept and rely conclusively on any instructions or other communications given by any Signatory named on this Form; and (iii) to assume that the authority of any Signatory continues in effect until the Program Manager receives written notice to the contrary.
7. I acknowledge that at all times there will be at least one person designated as a Control Person for the Entity. Upon the need for a replacement Control Person, the Entity will promptly submit a Form completed by the replacement Control Person.
8. I acknowledge that should one or more Signatory leave the Entity or no longer serve in a role where they have the authority to manage Kansas ABLE Savings Plan Accounts as a Signatory, the Control Person will immediately notify the Kansas ABLE Savings Plan and submit an updated Form.
9. I understand that I may be required to temporarily collect and transmit to the Plan the Social Security numbers or taxpayer identification numbers and other information of the Beneficial Owners of the Entity so that the Program Manager may conduct its identity verification process. I further understand that I am only to collect and transmit such information to the Plan exclusively for the purpose of the Entity identity verification process and will not use it for any unlawful purpose.
10. The Entity agrees to the terms and conditions of the Kansas ABLE Savings Plan Disclosure Booklet as currently in effect and agrees to be bound by the terms and conditions of any Supplement to the Kansas ABLE Savings Plan Disclosure Booklet issued by the Plan during the time that the Entity serves as an Authorized Individual for any Kansas ABLE Savings Plan Account.
11. I understand that Kansas ABLE Savings and each of the Kansas ABLE Savings Plan Administrators will not assume any liability for acts by or omissions of the Entity, the Control Person or any designated Signatory. Further, Kansas ABLE Savings and each of the Kansas ABLE Savings Plan Administrators are not liable in any way for actions taken or omissions made in reliance on instructions from the Control Person or any of the Signatories named on this Form. The Entity will indemnify and hold harmless Kansas ABLE Savings and each of the Kansas ABLE Savings Plan Administrators from and against any and all loss, damage, liability, or expense, including reasonable attorneys' fees, that any of them may incur by reason of, or in connection with, any misstatement or misrepresentation made by the Entity, the Control Person, or any Signatory with respect to the information provided on this Form or the Account, and any breach by the Entity, the Control Person or any Signatory of any of the agreements, representations, or warranties, contained in the Participation Agreement that is part of the Kansas ABLE Savings Plan Disclosure Booklet.
12. This Form will remain in full force and effect until revoked by a Control Person of the Entity.

I am duly authorized to execute this Form. I know and understand the contents of this Form, and all statements on this Form are true and correct.

SIGNATURE

Signature of Control Person

☐☐ – ☐☐ – ☐☐☐☐

Date (mm/dd/yyyy)

Title of Control Person

State of _____

County of _____

This record was acknowledged before me on

_____ by _____

Date

Name(s) of person(s)

as _____ [type of authority, such as officer or trustee] of

_____[name of party on behalf of whom record was executed].

SIGNATURE

Signature of Notarial Officer

☐☐ – ☐☐ – ☐☐☐☐

Date (mm/dd/yyyy)

Official Stamp

Title of Office _____

Name of Notary (First, Middle Initial, Last)

My commission expires:

☐☐ – ☐☐ – ☐☐☐☐

Date (mm/dd/yyyy)