Mississippi ABLE
a member of
The National ABLE Alliance

Mississippi ABLE

Account Owner Removes Authorized Individual Form

If you are an Account Owner with Legal Capacity, including Account Owners who have reached the age of majority and have Legal Capacity, you can use this form to:

- Remove the existing Authorized Individual(s) from your Account and become the sole signatory on your Account. (Complete **Sections 1, 2,** and **3**.**)**
- If, after removing the current Authorized Individual(s), an Account Owner with Legal Capacity wishes to designate any person or Entity to act as Authorized Individual they must appoint this person or Entity as their agent under a power of attorney and have the new Authorized Individual submit a completed **Authorized Individual Change of Signatory Form** to the Plan.
- By completing this form, the mailing address for the Account will be changed to the Account Owner's mailing address listed in **Section 1** below.
- If E-Delivery was established on the Account, the Plan will revert the Account back to paper delivery. In order to re-establish E-Delivery on the Account, the Account Owner must go online to register the email address provided below.
- Review the Plan Disclosure Booklet prior to completing this form for important information about the Plan.

1.888.609.3469
8 a.m. to 5 p.m. CT M-F

FAX 1.617.559.8944

ms.savewithable.com

ms.clientservice@savewithable.com

Regular mailing address:
Mississippi ABLE
P.O. Box 219564
Kansas City, MO 64121

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

- Capitalized terms used in this form, but not defined in this form, have the meanings provided in the Plan Disclosure Booklet.
- Type or print clearly, printing in capital letters and black ink. Please mail the form to Mississippi ABLE. Do not staple.

Forms can be downloaded from our website at **ms.savewithable.com**, or you can call Customer Service to request any form — or request assistance in completing this form — at **1.888.609.3469** any business day from 8 a.m. to 5 p.m. CT.

1. Account Owner Information – all information must be provided

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Account Number

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Account Owner's Legal First Name (M.I.)

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Account Owner's Legal Last Name

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Last 4 digits of Account Owner's Social Security Number

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Telephone Number

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Account Owner's Permanent Street Address (P.O. boxes are not acceptable).

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City State Zip Code

Account Owner's Mailing Address (if different from above)

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Street Address or P.O. Box

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City State Zip Code

Note: Account Owners will receive Account statements, transaction confirmations, tax forms and other Account-related correspondence at the mailing address listed above.

Email Address for Account Communications from the Plan

Only one email address can be associated with the Account. If the Account Owner will become the sole signatory for the Account, this should be an email address to which the Account Owner has access.

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IMPORTANT: Providing an email address here does not establish E-Delivery. If E-Delivery was previously established on the Account, the Plan will revert the Account back to paper delivery after receiving this completed form. In order to re-establish E-Delivery on the Account, the Account Owner must visit the Plan website and register for E-Delivery. By establishing E-Delivery, the Annual Account Maintenance Fee will be reduced. If the Account is invested in the Checking Account Option, E-Delivery for the checking account statements must be re-established, and a new debit card in the name of the Account Owner must be requested, if desired, at www.53.com/ABLE.

2. Account Owner removes all existing Authorized Individual(s) and assumes sole signature authority

Complete this section if you are an Account Owner with Legal Capacity, including Account Owners who have reached age of majority and who have Legal Capacity, and want to remove all existing Authorized Individual(s) from your Account and become the sole signatory on your Account.

INITIALS As an Account Owner with Legal Capacity, I am removing all Authorized Individuals from my Account. I understand that I am now the sole signatory on my Mississippi ABLE Account.

3. ACKNOWLEDGMENT, CERTIFICATIONS & SIGNATURE

I understand that by signing below, I authorize the changes described on this form, and I hereby acknowledge that I have received, read, understand, and agree to the terms and conditions of the Plan Disclosure Booklet (which includes a Participation Agreement and the Fifth Third Terms and Conditions) as in effect on the date hereof which govern all aspects of this Account and are incorporated herein by reference. I will retain a copy of the Plan Disclosure Booklet for my records. Additionally, I agree to be bound by the terms and conditions of any Supplement or revision to the Plan Disclosure Booklet issued by the Plan during the time that I am an Account Owner. Capitalized terms that are used in this form, but not defined herein, have the meanings provided in the Plan Disclosure Booklet.

I acknowledge and agree that I am bound by the terms, rights, and responsibilities stated in the Plan Disclosure Booklet and this form, and by any and all statutory, administrative, and operating procedures that govern the Plan. I understand that the Plan Disclosure Booklet, all subsequently added Supplements or revisions to the Plan Disclosure Booklet, Enrollment Form, and any subsequent forms signed by me constitute the entire agreement between me and the Plan. No person is authorized to make an oral modification to this agreement.

I understand that with the exception of the Checking Account Option, investments are not guaranteed or insured by the FDIC or any other government agency and are not deposits or other obligations of any depository institution. The Checking Account Option is insured by the FDIC up to $250,000, subject to certain limitations. Contributions to and returns earned on Investment Options are not guaranteed or insured by the Plan Administrators, as defined in the Plan Disclosure Booklet, and are subject to investment risks including the loss of the principal amount invested.

I understand that participation in the 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 understand that there is no guarantee that the Plan will continue to meet the requirements of Section 529A of the Code or that my Account will continue to be eligible to receive the benefit of Section 529A or the ABLE Act.

I acknowledge that I have received, read, and that by signing below, agree to the Fifth Third Terms and Conditions, which are part of the Plan Disclosure Booklet.

If the Account utilizes the recurring contributions or EFT option, I authorize the Plan and its designees, upon receipt of the applicable form or 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 the bank account associated with the Account. I authorize the bank to accept any such credits or debits to the account without responsibility to their correctness. I acknowledge that the origination of ACH transactions involving the bank account associated with the Account must comply with U.S. law. I further agree that the Plan Administrators or their authorized agents will not incur any loss, liability, cost, or expense for acting upon the receipt of telephone or online request. I understand that this authorization may be terminated by me at any time by notifying the Plan and the bank by telephone or in writing, and that the termination request will be effective as soon as the Plan 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 associated with the Account.

By signing this Removal of an Authorized Individual by an Account Owner Form, I am making the following certifications under penalties of perjury:

- I certify under penalties of perjury that all of the information I have provided on this form is accurate and complete.
- I certify under penalties of perjury that I will promptly notify the Plan if changes in the Account Owner's condition would result in the Account Owner no longer qualifying as an Eligible Individual.
- I certify under penalties of perjury that:
  - A) the Account Owner is blind (within the meaning of section 1614(a)(2) of the Social Security Act); or
  - B) the Account Owner has a medically determinable physical or mental impairment that results in marked and severe functional limitations (as that phrase is defined in §1.529A-2(e)(2) of the Tax Regulations) and that either can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.
- I certify under penalties of perjury that the Account Owner's blindness or disability occurred before the Account Owner attained age 26.
- If the basis for the Account Owner's eligibility is based on SSI or SSDI benefits, I certify, under penalties 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) to the Plan, the Plan Administrator, the IRS, or the U.S. Treasury Department if requested.
- If the basis for the Account Owner's eligibility is based on having a condition on the List of Compassionate Allowances Conditions maintained by the Social Security Administration, I certify, under penalties of perjury that: (1) I have identified the Account Owner's condition on the List of Compassionate Allowances Conditions, and (2) the condition was present and produced marked and severe functional limitations before the Account Owner attained age 26.
- If the basis for the Account Owner's eligibility is a diagnosis by a physician, I certify, under penalties 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 physician meeting the criteria of 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)), which includes the name and address of the diagnosing physician and the date of the diagnosis, and I will retain and provide a copy of the diagnosis and related information to the Plan upon request.
- I certify under penalties of perjury that the applicable diagnostic code [i.e., Codes 1-7] provided on the Enrollment Form identifying the type of the individual's impairment has been provided and is accurate.
- I certify under penalties of perjury that I will notify the Plan if my authority to serve as the signatory on this Account expires or is removed.
- If the Account Owner is an employed Account Owner (including self-employed individuals) as described in the Plan Disclosure Booklet and intends to make compensation contributions such that the total annual contributions to the Account will exceed the Basic Annual Contribution Limit, I certify under penalties of perjury that (1) the Account Owner is employed, (2) the Account Owner has neither made nor received contributions to a 401(k) or other defined contribution plan (within the meaning of section 414(i) of the Code with respect to which the requirements of sections 401(a) or 403(a) of the Code are met), 403(b) plan, 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 Plan Disclosure Booklet.
- I certify under penalties of perjury that I am of legal age in my state of residence and have the Legal Capacity to establish or manage an Account.
- I certify under penalties of perjury that I neither know nor have reason to know that the Account Owner already has an existing ABLE account.

I agree to promptly inform the Plan in the event that any of the foregoing certifications become untrue. I understand and acknowledge that the Plan has the right to suspend or terminate the Account and return the balance of the Account (which may result in a Non-Qualified Withdrawal) to the Account Owner, as applicable, if the Plan has reasonable grounds to believe that any of the foregoing certifications is untrue.

Signature of Account Owner

By signing below, I authorize the changes described on this form, and I agree that the changes on this form and my participation in the Mississippi ABLE Plan are subject to the Plan Disclosure Booklet, as amended from time to time.

SIGNATURE

Signature of Account Owner

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Date (mm/dd/yyyy)