AR ABLE
Achieving a Better Life Experience

Arkansas ABLE
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.

- You can enroll online at **ar.savewithable.com**.
- An individual can only have one ABLE Account nationwide.
- The Account can only be opened for an Eligible Individual.
- The Plan Disclosure Booklet contains important information about the Arkansas ABLE Plan including, among other information, the objectives, risks, fees and restrictions associated with opening an Account and investing in the Arkansas ABLE Plan. Capitalized terms used in this Enrollment Form and not defined, have the meanings provided in the Plan Disclosure Booklet.
- Before investing, you should check with your home State to determine if it offers tax or other benefits for investing in its own plan.

1.888.609.8874
7 a.m. to 4 p.m. CT M-F

ar.savewithable.com

ar.clientservice@savewithable.com

Regular mailing address:
Arkansas ABLE
P.O. Box 219092
Kansas City, MO 64121

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

- Type or print clearly, printing in capital letters and black ink. Please mail the form to the Arkansas ABLE Plan. Do not staple.

Forms can be downloaded from our website at **ar.savewithable.com**, or you can call us to order any form — or request assistance in completing this form — at **1.888.609.8874** any business day from 7 a.m. to 4 p.m. CT**.**

1. Account Type

Check one:

- ☐ I am opening the Account for myself
- ☐ I am opening the Account as the person or representative of an entity with authority to open the Account for an eligible minor. (By checking this box, you are required to complete **Section 3** of this form.)
- ☐ I am opening the Account as the person or representative of an entity with authority to open the Account for an eligible adult who has Legal Capacity as defined in the Plan Disclosure Booklet. (To check this box, the Account Owner must have designated you or your organization as an agent under power of attorney. You are required to complete **Section 3** of this form, and check box #1 next to "Power of Attorney" in **Section 3** and, sign **Section 8** of this form. You must retain the power of attorney with your records. To determine whether a copy of the power of attorney is required to be submitted with this **Enrollment Form**, see the cover page of this form, if present. A **Power of Attorney Form** is available at **ar.savewithable.com**.)
- ☐ I am opening the Account as the person or representative of an entity with authority to open the Account for an eligible adult who does not have Legal Capacity as defined in the Plan Disclosure Booklet. (By checking this box, you are required to complete **Section 3** of this form.)

2. Account Owner Information *(The Account Owner is the Eligible Individual with the disability who owns the Account and whose Qualified Disability Expenses will be paid from the Account. **All information in this section is required.**)*

Legal Name (First name) (M.I.)

Legal Name (Last name)

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

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

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, unless an Authorized Individual's address is provided in **Section 3** for this purpose.)*

City State Zip Code —

A. Account Owner's identity verification. *(Required for an Account Owner who is over the age of majority. This is not required for minors.)*

Note: 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 opens an account.

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

Please check one: ☐ Driver's license ☐ I.D. card ☐ Military I.D.

Account Owner's mother's maiden name

- ☐ The adult Account Owner does not have a driver's license, military I.D., or state-issued I.D. card. By checking this box the applicant acknowledges that the Account Owner will not be eligible to invest in the Checking Account Option.

B. Please select the Account Owner's Disability, the onset of which occurred prior to their 26th birthday:
(The following information is required by the federal government. Report only one primary code number for an Account Owner. If more than one code applies, select the most significant code.)

Note: Please DO NOT submit your written disability-related diagnosis or any protected health information (PHI). If we receive any PHI we will destroy it using secure means. For any additional questions please contact the Arkansas ABLE Plan at 1.888.609.8874.

- ☐ **Code 1** - Developmental Disorders: Autistic Spectrum Disorder, Asperger's Disorder, Developmental Delays and Learning Disabilities
- ☐ **Code 2** - Intellectual Disability: May be reported as mild, moderate, or severe intellectual disability
- ☐ **Code 3** - Psychiatric Disorders: Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD), Anorexia nervosa, Attention deficit/hyperactivity disorder (AD/HD), Bipolar disorder
- ☐ **Code 4** - Nervous Disorders: Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease, Multiple sclerosis, Severe sensorineural hearing loss, Congenital cataracts
- ☐ **Code 5** - Congenital Anomalies: Chromosomal abnormalities, including Down Syndrome, Osteogenesis imperfecta, Xerodermatic pigmentosum, Spinal muscular atrophy, Fragile X syndrome, Edwards syndrome
- ☐ **Code 6** - Respiratory Disorders: Cystic Fibrosis
- ☐ **Code 7** - Other: Includes Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease, Hemophilia, and any other disability not listed under Codes 1 - 6

C. Basis under which ABLE eligibility is asserted: *(Select only one)*

- ☐ The Account Owner is receiving SSDI (Social Security Disability Insurance) based on a disability.
- ☐ The Account Owner is receiving or is entitled to receive SSI (Supplemental Security Income) based on a disability.
- ☐ The Account Owner's disability is identified on the Social Security Administration's List of Compassionate Allowances Conditions (see ssa.gov/campassionateallowances). The disability causes marked and severe functional limitations.
- ☐ A doctor diagnosed the Account Owner with a physical or mental disability. The disability causes marked and severe functional limitations. It is expected to last for more than 12 months, or is a terminal condition. I will keep a copy of the diagnosis that is signed by a physician who meets the criteria of Section 1861(r)(1) of the Social Security Act and includes the physician's name and address, as well as the date of the diagnosis. Please **DO NOT** submit your written disability-related diagnosis, only check this box and keep your diagnosis documentation with you.

  Note: For purposes of ABLE eligibility, marked and severe functional limitations means the standard of disability in the Social Security Act for children claiming SSI benefits, but without regard to age or whether the Account Owner engages in substantial gainful activity. Specifically this is a level or severity that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404. See 20 CFR 416.906, 416.926a. Refer to the Plan Disclosure Booklet for a full description.

3. Authorized Individual

To be completed by the person, or by an authorized representative of an entity in the name of the entity, who is opening the Account as an Authorized Individual. Do not complete this section if you are opening the Account for yourself.

The Authorized Individual is the person or entity that can transact on the Account on behalf of the Account Owner. The Authorized Individual may be any person or entity selected by an Account owner with Legal Capactiy, or the Account Owner's agent under a power of attorney, or, if none, a conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed by the Social Security Administration, in that order of priority.

For Entities: Provide the name of the entity in the First or Last Name boxes. Provide the entity's taxpayer identification number. Leave the birth date and citizenship boxes blank. Include the telephone number, street and mailing address of the entity. Please contact the Arkansas ABLE Plan for more information.

- An Account can have more than one Authorized Individual; however, all Authorized Individuals must be at the same priority level on the list of possible Authorized Individuals. An additional Authorized Individual can be added by completing the **Add an Authorized Individual Form** available online at **ar.savewithable.com**. For Account Owners who have Legal Capacity and who select the Checking Account Option, the debit card and checks will be issued in the name of the Account Owner. For Account Owners who lack Legal Capacity, the Checking Account Option debit card will be issued in the name of the Authorized Individual and the checks will be issued in the name of the Account Owner by the Authorized Individual. When multiple Authorized Individuals are named, it is the responsibility of the Authorized Individuals to manage the Account in accordance with any legal documentation, such as guardianship documents or powers of attorney, that requires them to act together. If legal documentation requires Authorized Individuals to act together, it is the duty of the Authorized Individuals to reach agreement before either takes any action in managing and transacting on the Account. For Accounts with the Checking Account Option, only one Authorized Individual will be permitted to access the checking account, write checks, and use the debit card. Note that some States may require the submission of a separate release form when multiple Authorized Individuals are required to act together.

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Authorized Individual's First Name (M.I.)

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Authorized Individual's Last Name

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

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

The Authorized Individual's address indicated here will be used as the Account's address of record for all Account mailings.

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

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

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City State Zip Code

☐ Check if Mailing address is the same as the permanent address.

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Account Mailing Address if different from above *(The mailing address indicated here will be used as the Authorized Individual's address of record for all Account mailings.)*

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City State Zip Code

I hereby certify under penalties of perjury that I am: *(Select all that apply)*

1. ☐ Power of Attorney
2. ☐ Conservator OR ☐ Legal Guardian
3. ☐ Spouse
4. ☐ Parent
5. ☐ Sibling
6. ☐ Grandparent
7. ☐ SSA-appointed Representative Payee

INITIALS I hereby certify under penalties of perjury that I am the above-selected Authorized Individual type and that any legal documentation provided by me is true and correct. (See the Plan Disclosure Booklet and the cover page, if present, to determine what documentation, if any, the Plan requires to confirm the Authorized Individual's relationship to the Account Owner and authority to manage the Account on behalf of the Account Owner).

If I am opening the Account for an eligible minor or an eligible adult who does not have Legal Capacity, I certify under penalties of perjury that no other person or entity that is willing and able to act as Authorized Individual ranks higher on the above list of possible Authorized Individuals.

If I am opening the Account for an eligible adult who has Legal Capacity, I certify under penalties of perjury that I am the person or representative of the entity selected by the Eligible Individual to establish the Account on their behalf.

I further certify under penalties of perjury that I will notify the Arkansas ABLE Plan if my authority expires or is removed.

Authorized Individual's Identity Verification. *(Required)*

Note: 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 opens an account.

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

Please check one: ☐ Driver's license ☐ I.D. card ☐ Military I.D.

Authorized Individual's mother's maiden name

☐ I do not have a driver's license, military I.D., or state-issued I.D. card. By checking this box I acknowledge that the Account Owner will not be eligible to invest in the Checking Account Option.

4. Email Address and E-Delivery

You can provide your email address below to receive communications from the Plan. Providing an email address here does not establish E-Delivery. ***Only one email address can be associated with the Account.***

After the Account is open, you can visit the Plan website to establish E-Delivery for the Account. By establishing E-Delivery, the Annual Account Maintenance Fee will be reduced. If the Checking Account Option is selected, you can establish E-Delivery for Checking Account Option statements at **www.53.com/ABLE** after the checking account is open and you have received your free debit card and confirmation of your deposit.

Please note that entities (group homes, care providers, etc.) must provide a continuously monitored organizational email address that is not exclusively associated with a specific employee.

The Plan reserves the right to discontinue E-Delivery at any time.

Provide your email address below:

Email Address *(This is the email address to which all communications from the Plan should be sent)*

5. Investment Option Selection

- Before choosing your Investment Option(s), please read the Plan Disclosure Booklet, available at **ar.savewithable.com,** which contains important information about the Investment Options.
- Please select one or more Investment Options from the choices below and indicate how much you would like to allocate to each option.
- Please make sure to use whole percentages only and ensure that your total selection equals 100%.
- You do not have to select every option.
- If you choose only one Investment Option please indicate 100% next to that option.

Aggressive Option	☐☐☐ %
Moderately Aggressive Option	☐☐☐ %
Growth Option	☐☐☐ %
Moderate Option	☐☐☐ %
Moderately Conservative Option	☐☐☐ %
Conservative Option	☐☐☐ %
Checking Account Option	☐☐☐ %
Total	**1 0 0 %**

Information about the Checking Account Option

- You will receive a free debit card within 10 calendar days after the Checking Account Option is funded. Contributions into the Checking Account Option will be available for withdrawal after 6 or 7 business days.
- You have the option to order checks for a $6 fee.
- To update statement delivery preferences for the Checking Account Option, please log onto www.53.com/ABLE once you obtain your free debit card.
- The Checking Account Option may be unavailable to certain Accounts due to legal restrictions, for instance if the Account requires two signatures for all withdrawals.

☐ *(optional)* Please send me a checkbook. A fee of $6 will be assessed to the Checking Account Option. The checkbook will be shipped when the balance of the Checking Account Option is at least $25.

The Arkansas ABLE Plan also offers a **Systematic Exchange Program.** A Systematic Exchange Program is a method of automatically moving money from one Investment Option to another Investment Option. If you are interested in participating in this feature please complete the **Account Financial Features Form** available online at **ar.savewithable.com**. If you establish a Systematic Exchange Program at the time of your enrollment, it will not be deemed an investment election change for purposes of the twice-per-calendar-year limit. If you establish a Systematic Exchange Program after your enrollment, it will count as an investment election change against that limit.

6. Contribution Method *(At least one contribution method is required)*

- Your initial contribution can come from several sources, 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 to the Target Risk Options will be held for 5 or 6 business days before becoming available for withdrawal and contributions to the Checking Account Option will be held for 6 or 7 business days before becoming available for withdrawal.
- The minimum initial and subsequent contribution into the Arkansas ABLE Plan account is $25.

Note: The Annual Contribution Limit is equal to the annual gift tax exclusion amount ($18,000 as of January 1, 2024). An ABLE Account Owner with earned income may be eligible to make additional contributions exceeding this limit. Please contact the Arkansas ABLE Plan for more information and read the Plan Disclosure Booklet.

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

A. ☐ **Check.**
Important: All checks must be payable to the Arkansas ABLE Plan.
$☐☐,☐☐☐,☐☐
Amount

B. ☐ **Recurring contributions.** You can have a set amount automatically transferred from a bank, savings and loan, or credit union account monthly or quarterly. Money will be transferred into your Arkansas ABLE 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 **ar.savewithable.com** or by calling **1.888.609.8874**. Account Owners, family members, and friends can all contribute to the Arkansas ABLE Plan Account through recurring contributions. To add additional recurring contribution instructions or multiple bank accounts, attach a separate page with the information requested in **Sections 6B** and **7** for each additional recurring contribution instruction or bank account.

Important: To set up this option, you must provide bank information in **Section 7**. If the bank account owner is not the same as the Account Owner or the Authorized Individual, complete an **Account Financial Features Form** available online at **ar.savewithable.com**.

Amount of Debit: ☐ $25 ☐ $50 ☐ $100 ☐ $150 ☐ Other **$**☐☐,☐☐☐,☐☐
Amount

Frequency *(Check One)***:** ☐ Monthly ☐ Quarterly (Every three months)

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

*The Arkansas ABLE Plan must receive instructions at least 3 business days prior to the start date specified. If the date is not specified, this recurring contribution will begin on the 15th day of the month following receipt of the request.

C. ☐ **Payroll Direct Deposit.** If you want to make contributions to the Arkansas ABLE Plan Account directly from a paycheck, first contact your employer's payroll office to verify that you can participate. After verifying, please complete and sign a **Payroll Direct Deposit Form** and submit to the Arkansas ABLE Plan. The Arkansas ABLE Plan will send you a **Payroll Direct Deposit Confirmation Form** to complete and submit to your employer's payroll office.

D. ☐ **Electronic Fund Transfer (EFT).** Through EFT, you can make contributions online at any time or by phone during normal business hours by transferring money from a bank account. We will keep the bank information on file for future EFT contributions. To set this up, you must provide bank information in **Section 7**. *(The amount below will be a one-time EFT contribution to open the Account.)*
$☐☐,☐☐☐,☐☐
Amount

E. ☐ **Rollover from another state's ABLE program to the Arkansas ABLE Plan**. Complete and include an **Incoming Rollover Form**, available online at **ar.savewithable.com**, or by calling **1.888.609.8874**. By law, rollovers between ABLE plans for the same Account Owner are permitted only once every 12 months.

$ __ __ , __ __ __ , __ __
Amount

F. ☐ **Rollover from a 529 Plan to the Arkansas ABLE Plan.** Complete and include an **Incoming Rollover Form**, available online at **ar.savewithable.com**, or by calling **1.888.609.8874**. By law, rollovers between 529 and ABLE plans for the same Account Owner are permitted only once every 12 months. You may roll all or part of the assets from a 529 plan account into the Arkansas ABLE Plan Account for the same beneficiary or a "member of the family" as defined by Section 529 of the Internal Revenue Code within 60 days of withdrawal. If you are moving assets from a 529 plan, the amount of the rollover—combined with any contributions you have made to this ABLE Account in the current year—cannot exceed the Annual Contribution Limit. Please see the Plan Disclosure Booklet for details.

$ __ __ , __ __ __ , __ __
Amount

7. Bank Information.

Recurring contributions 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. If the bank account owner is not the same as the Account Owner or the Authorized Individual, complete an ***Account Financial Features Form*** *available online at* **ar.savewithable.com**. *Money market mutual funds and cash management accounts offered through non-bank financial companies cannot be used.*

Bank Name

Bank Routing Number

Bank Account Number

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

Name(s) on Bank Account

Name *(First, Middle Initial, Last)*

Name *(First, Middle Initial, Last)*

8. ACKNOWLEDGEMENTS, CERTIFICATIONS & SIGNATURE

I understand that by signing below, I hereby acknowledge that I have received, read, understand, and agree to the terms and conditions of the Plan Disclosure Statement (which includes a Participation Agreement and the Fifth Third Terms and Conditions) and the Plan Addendum (collectively, the Plan Disclosure Booklet) 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 or Authorized Individual. Capitalized terms that are used in this Enrollment 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 Enrollment 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.

If I am selecting the Checking Account Option, I hereby acknowledge that I have received, read, and that by signing below, agree to the Fifth Third Terms and Conditions.

If I have chosen the recurring contributions or EFT option, I authorize the Plan 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 the account at the bank named on this Enrollment Form. 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 the bank account named on this Enrollment Form must comply with U.S. law. I further agree that the Plan Administrators 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 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 identified by me on this Enrollment Form.

By signing this Enrollment 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 Enrollment Form is accurate and complete, including without limitation, the information regarding the Account Owner's disability, the Account Owner's status as an Eligible Individual, and the basis for the Account Owner's eligibility.
- 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, on this Enrollment Form, I selected that 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, on this Enrollment Form, I selected that 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 on this Enrollment Form, I selected that 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] requested on this Enrollment Form identifying the type of the individual's impairment has been provided and is accurate.

- I certify under penalties of perjury that: (1) I am establishing the Account for myself as the Eligible Individual, or I am the person or representative of the entity selected by the Eligible Individual to establish the Account on their behalf, or if the Eligible Individual is unable to establish the Account, I have, or the entity that I represent has, the authority to establish the Account as the Eligible Individual's agent under a power of attorney, or if none, conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed for the Eligible Individual by the Social Security Administration, in that order of priority; and (2) no other person or entity that is willing and able to establish this Account ranks higher than I do or the entity that I represent does on the list described in (1).

- 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 $18,000, 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)) with respect to which the requirements of sections 401(a) or 403(a) are met), 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 Plan Disclosure Booklet.

- If I am establishing the Account for myself, 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.

- If I am establishing the Account for an eligible minor, I certify under penalties of perjury that I am of legal age in my state of residence and that I am either the parent of the Account Owner or a person with appropriate authorization to manage an ABLE account for the Account Owner, including the ability to open, transact, and maintain an Account on behalf of the Account Owner.

- If I am opening the Account as the Authorized Individual for an adult who a) lacks the Legal Capacity to establish or manage an Account, or b) has Legal Capacity to establish or manage an Account and has granted me power of attorney, I certify under penalties of perjury that I am of legal age in my state of residence and that I have appropriate authorization to manage an ABLE account for the Account Owner, including the ability to open, transact, and maintain a financial account on behalf of the Account Owner.

- If I am opening the Account as the Authorized Individual for an adult who has granted me power of attorney, I certify under penalties of perjury that (1) the Account Owner was able and competent at the time the power of attorney was executed, (2) the power of attorney remains in full force and effect and has not been withdrawn, amended or removed, and (3) the Account Owner is still living.

- 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, other than an ABLE account that will terminate via Rollover or program-to-program transfer of its assets into this Account. If I am establishing this Account through a Rollover from an account in another ABLE program, I agree to close the other account no later than the 60th day after the entire account balance was distributed from the other ABLE account. I acknowledge that failure to do so will result in my Account not being treated as an ABLE account. The consequences of an account not being treated as an ABLE account include loss of favorable tax treatment and possible loss of eligibility for resource-based benefits such as SSI and Medicaid.
- If I am rolling over assets from another ABLE program, I certify under penalties 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 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 withdrawal may be 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

Signature of Account Owner *(or Authorized Individual listed in **Section 3**)*

☐☐ – ☐☐ – ☐☐☐☐

Date *(mm/dd/yyyy)*

9. Additional Information *(Optional)*

How did you hear about the Arkansas ABLE Plan? *(Select One)*

- ☐ Family/Friend
- ☐ Organization
- ☐ Employer
- ☐ School Event
- ☐ Arkansas ABLE Plan Website
- ☐ Special Olympics
- ☐ Other
- ☐ Advisor
- ☐ Ad
- ☐ Email
- ☐ Magazine
- ☐ Mailing
- ☐ Center for Independent Living