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 Documents contain important information about Arkansas ABLE and the National ABLE Alliance, including, among other information, the objectives, risks, charges, expenses, and restrictions in connection with opening and investing in Arkansas ABLE. Capitalized terms used in this Enrollment Form and not defined, have the meanings provided in the Plan Disclosure Documents.
- Before investing, you should check with your home state to determine if it offers tax or other benefits for investing in its own plan.
- Type or print clearly, printing in capital letters and black ink. Please mail the form to Arkansas ABLE. Do not staple.

1.888.609.8874
8 a.m. to 5 p.m. ET 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
920 Main Street, Suite 900
Kansas City, MO 64105

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 8 a.m. to 5 p.m. ET**.**

1. Account Type

Check one:

☐ I am opening the Account for myself. At a minimum, please complete **Sections 2, 7, 8** and **10** of this form.

☐ I am opening the Account as the Authorized Individual *(parent or other person with the authority to open the account)* of a minor Account Owner. I certify that I am the parent or individual with the legal authority to manage an ABLE account on behalf of the Account Owner. At a minimum, please complete **Sections 2, 3, 7, 8** and **10** of this form.

☐ I am opening the Account as the Authorized Individual of an eligible adult Account Owner who a) lacks the capacity to contract, or b) has legal capacity, and has granted me power of attorney. At a minimum, please complete **Sections 2, 3, 7, 8** and **10** of this form.

☐ As the Authorized Individual, I am enclosing the authorizing documentation (Example: guardianship, conservator, court document or legal document) showing I have the authority to make financial transactions on behalf of the Account Owner. **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.**

IMPORTANT: This authorizing documentation is required. If you are unsure which documents to provide, please contact **Arkansas ABLE** at **1.888.609.8874**.

2. Account Owner Information *(The Account Owner is the person with the disability—the Eligible Individual—who owns 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/Trust 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.)*

City — State — Zip Code

A. Account Owner's identity verification. *(Required for an Account Owner who is over the age of majority.)*

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 ☐ Military I.D.

Account Owner's mother's maiden name

☐ **I do not have a driver's license or state-issued I.D. card, and by checking this box I acknowledge that I will not be eligible to invest in the Checking Investment 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 and will only be used for aggregate reporting purposes. Report only one primary code number for an Account Owner. If more than one code applies, select the most significant code.)

- ☐ **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 entitled to Supplemental Security Income benefits under Title XVI of the Social Security Act. *(SSI Benefits Eligibility)*
- ☐ The Account Owner is entitled to Social Security Disability benefits under Title II of the Social Security Act. *(SSDI Benefits Eligibility)*
- ☐ The Account Owner is entitled to receive Social Security disability benefits (SSI or SSDI) or has a similarly severe disability and possesses a written diagnosis from a licensed physician. *(To open an account under this basis you hereby certify that the Account Owner has a physical or mental disability that can be expected to last for at least a year or can cause death; or the Account Owner is blind; or the Account Owner's disability is included on the Social Security Administration's List of Compassionate Allowances Conditions; and such blindness or disability occurred before age 26.)* Please **DO NOT** submit your written disability-related diagnosis, only check this box and keep your diagnosis documentation with you.

3. Authorized Individual *(Do not complete this section if you are opening an account for yourself. All information is required in this section if you are an Authorized Individual who is opening the account on behalf of the Account Owner.)*

Complete this section if you are opening an Account as an Authorized Individual *(parent or other person with the authority to open the account)* of a minor Account Owner or as an Authorized Individual of an adult Account Owner who either a) lacks the capacity to contract and for whom you have authority to act, or b) has legal capacity and has granted you power of attorney.

The Authorized Individual is the person who can transact on the Account on behalf of the Account Owner, therefore the Authorized Individual must have the authority to manage an ABLE account on behalf of the Account Owner. The Authorized Individual's address listed in **Section 3** will be used as the Account's address of record for all Account mailings.

Important: If more than one individual has the authority to manage an ABLE account on behalf of the Account Owner as indicated by the authorizing documentation, please complete **Sections 3** and **4**.

- If the legal documentation providing the authority to be an Authorized Individual requires (not just permits) that more than one person sign legal documents, all required individuals must be Co-Authorized Individuals. In this case, selection of the Checking Option will not be allowed.

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

Authorized Individual's Last Name

Social Security Number or Taxpayer Identification Number

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

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

Telephone Number

☐ 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

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

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

City State Zip Code

A. Authorized's Identity Verification. *(Required for an Account Owner who is over the age of majority.)*

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 ☐ Military I.D.

Account Owner's mother's maiden name

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

4. Co-Authorized Individual *(Complete this section to allow for another Authorized Individual. All fields are required.)*

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

Co-Authorized Individual's Last Name

Social Security Number or Taxpayer Identification Number

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

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

Telephone Number

☐ 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

5. Authorized Agent *(Complete this section to allow for another party to receive information or transact on this account.)*

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

Authorized Agent's Last Name

Social Security Number or Taxpayer Identification Number

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

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

Telephone Number

☐ 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

A. Authorization Level

I, the Account Owner or Authorized Individual(s) listed in **Section 2, 3,** (and **4**) appoint the individual listed in **Section 5** as a Level 1 agent. *(Please initial next to Level 1 - Account Inquiry Access)* **Please see Section B, below for information regarding other levels of access.**

☐ **Level 1 — Account Inquiry Access.**

- Obtain information about the account
- Receive duplicate Account statement from Arkansas ABLE

B. Other Authorization Levels Available *(These levels require a completed **Power of Attorney Form**. Please visit **ar.savewithable.com** or call **1.888.609.8874** to access this form.)*

Level 2 — Authorization - Level 1 plus the following.

- Contribute money to the Account
- Move money among Investment Options within the Account. Level 2 access may be granted by completing the ***Power of Attorney Form***. This form is available at **ar.savewithable.com** or by calling **1.888.609.8874**.

Level 3 — Authorization - Levels 1 and 2 plus the following.

- Withdrawal now or in the future, money from the account. Level 3 access may be granted by completing a ***Power of Attorney Form***. This form is available at **ar.savewithable.com** or by calling **1.888.609.8874**.

Level 4 — Full Power of Attorney ("POA")/Level 4 — grants full Power of Attorney to transact on the account. A Full POA has the same access and abilities as the Account Owner.

Level 4 access may be granted by completing a ***Power of Attorney Form***. This form is available at **ar.savewithable.com** or by calling **1.888.609.8874**.

6. Email Address *(One email address can be associated to your account):*

IMPORTANT: Once your account is established, you can select e-delivery notification by visiting **ar.savewithable.com**, registering your account online, and selecting e-delivery notification of statements and/or confirmations when asked for your delivery preference during the registration process. If you select electronic delivery (e-delivery) notification for statements and/or confirmations, your Quarterly Account Maintenance Fee will be discounted by $3.75. You may also choose to receive your year-end statement via paper delivery and remain eligible for the discount. If you provide your email address below, we will send you an email with instructions on how to register your account online.

If you plan to or have invested in the Checking Option, you will need to separately log into www.53.com to change your delivery preferences. By selecting electronic statement delivery you will be eligible to receive a waiver of the monthly service fee of $2.00. To update your statement delivery preferences for your Checking Option, please log into www.53.com once you obtain your free debit card.

Please note: After you select e-delivery notification, if an email is returned as "undeliverable", we'll attempt to resend it. If the notice continues to be undeliverable after multiple attempts, your delivery preference will be changed to paper, and statements, confirmations, tax forms and other correspondence will be delivered to you via U.S. Mail and you will not be eligible for the discounted Quarterly Account Maintenance Fee. We reserve the right to discontinue electronic delivery at any time.

Please provide your email address below:

Email Address

7. Investment Option Selection

- Before choosing your Investment Option(s), please read the Plan Disclosure Documents, available at **ar.savewithable.com** which contain important information about the Investment Options.
- 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.
- All future contributions will follow the same percentages unless otherwise indicated.
- Use whole percentages only.
- Your total Investment Option percentages must equal 100%.

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

Information about the Checking Option

- You will receive a free debit card within 10 calendar days after the Checking Option is funded. Contributions into the Checking Option will not be available for withdrawal for six business days.
- You have the option to order checks for a $6 fee.
- Account Owner information must be completed in Section 2.
- If the Account Owner is a minor or if there is an Authorized Individual on the Account, please also complete Section 3.
- The Checking 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 that contains 50 checks. A fee of $6 will be assessed to the Checking Option. The checkbook will be shipped when the balance of the Checking Option is at least $25.

*Identity Verification information in **Sections 2A** and **3A** 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.*

Arkansas ABLE 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. *(This can be a useful tool in the event you desire to pay for recurring expenses from the Checking Option).* If you are interested in participating in this 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.

8. Contribution Method

- 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 will be held for 5 business days before becoming available for withdrawal (6 business days for checking option).
- The minimum initial and subsequent contribution into an Arkansas ABLE account is $25.

Note: The annual contribution limit is equal to the annual gift tax exclusion amount ($15,000, beginning in 2018). An ABLE Account Owner with earned income may be eligible to make additional contributions exceeding this limit. Please contact Arkansas ABLE for more information.

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

A. ☐ **Check.**
Important: All checks must be payable to Arkansas ABLE.

$☐☐,☐☐☐.☐☐
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 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 an Arkansas ABLE Account through recurring contributions. To add additional recurring contribution instructions or multiple bank accounts, attach a separate sheet with the information requested in **Sections 8B** and **9** for each additional recurring contribution instruction or bank account.

Important: To set up this option, you must provide bank information in **Section 9.** If the Bank Account Owner is not the same as the Account Owner or the Authorized Individual, complete an **Account 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)*

*Arkansas ABLE must receive instructions at least 3 business days prior to the start date 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 recurring contribution option will begin the month following the receipt of this request, on the 15th day of the month.

C. ☐ **Payroll Direct Deposit.** If you want to make contributions to your Arkansas ABLE 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 Arkansas ABLE, provided your signature, and your Social Security or taxpayer identification number on the form, and submitted the form to your employer's payroll office.

Amount of Payroll Direct Deposit each pay period: $☐,☐☐☐.☐☐

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 9**. *(The amount below will be a one-time EFT contribution to open your Account.)*

$☐☐,☐☐☐.☐☐
Amount

E. ☐ **Rollover from another state's ABLE program to** Arkansas ABLE. 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** Arkansas ABLE**.** 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 an Arkansas ABLE account for the same beneficiary or a "Member of the Family" of the prior beneficiary 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 maximum contribution limit, currently $15,000.

$☐☐,☐☐☐.☐☐
Amount

9. Bank Information.

Required to establish the recurring contributions or EFT service. 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. 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

If the Bank Account Owner is not the same as the Account Owner or the Authorized Individual, complete an **Account Features Form** available online at **ar.savewithable.com**.

Names on Bank Account

Name *(First, Middle Initial, Last)*

Name *(First, Middle Initial, Last)*

10. Signature — YOU MUST SIGN BELOW

1. By signing below, I hereby acknowledge that I have received, read, and agree to the terms and conditions of the Plan Disclosure Statement (which includes a Participation Agreement) and Arkansas ABLE Addendum, if any, (collectively, the Plan Disclosure Documents) as in effect on the date hereof which governs all aspects of this Account and is incorporated herein by reference. I will retain a copy of the Plan Disclosure Documents for my records. Additionally, I agree to be bound by the terms and conditions of any Supplement to the Plan Disclosure Documents issued by Arkansas ABLE during the time that I am an Account Owner or Authorized Individual.
2. 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.
3. I certify, under penalties of perjury that I will promptly notify Arkansas ABLE if changes in the Account Owner's condition would result in the Account Owner no longer qualifying as an Eligible Individual.
4. I acknowledge and agree that I am bound by the terms, rights and responsibilities stated in the Plan Disclosure Documents and this form, and by any and all statutory, administrative and operating procedures that govern Arkansas ABLE.
5. I understand that the Plan Disclosure Documents, all subsequently added Supplements to the Plan Disclosure Documents, **Enrollment Form** and any subsequent forms signed by me constitute the entire agreement between me and Arkansas ABLE. No person is authorized to make an oral modification to this agreement.
6. If the Account Owner is an Eligible Individual based on SSI or SSDI Benefits Eligibility, I certify under penalty of perjury that the Account Owner (1) is entitled to benefits based on blindness or disability under Title II or XVI of the Social Security Act and has received a benefit verification letter from the Social Security Administration and agrees to retain and provide the letter (or a genuine copy of the letter or other evidence) to Arkansas ABLE, Arkansas Administrator, the IRS, or the U.S. Treasury Department upon request; and (2) the Account Owner's disability was present before the Account Owner attained age 26.
7. If the Account Owner is an Eligible Individual based on Certification Eligibility, I certify under penalty of perjury that the Account Owner (A) (1) is blind (within the meaning of section 1614(a)(2) of the Social Security Act) or 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; and (2) possess a written diagnosis related to the impairment signed by physician that meets Social Security Act criteria; and (3) the impairment occurred before the date on which the Account Owner attained age 26; (B) (1) has a condition listed in the ''List of Compassionate Allowances Conditions'' maintained by the Social Security Administration and that such condition occurred before the date on which the Account Owner attained age 26.
8. Except for the Checking Option, I understand 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. Investments are not guaranteed or insured by the Plan Administrators (as defined in the Plan Disclosure Documents) and are subject to investment risks including the loss of the principal amount invested.
9. I understand that participation in Arkansas ABLE 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.
10. I understand that there is no guarantee that Arkansas ABLE 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 that Section.
11. If I am rolling over assets from another ABLE program, by signing below 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 further understand that moving assets among investment options within Arkansas ABLE will count towards my permitted twice per calendar year Investment Option change limit.
12. If I have chosen the recurring contributions or EFT option, I authorize Arkansas ABLE 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 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 Arkansas ABLE and the bank by telephone or in writing, and that the termination request will be effective as soon as Arkansas ABLE 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 9**.

Signature *(cont.)*

13. If I am opening 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 contract. If I am opening the Account as the Authorized Individual for a minor child, 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 authorizing documentation that grants me the ability 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 a) lacks the legal capacity to enter into a contract, or b) has legal capacity 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 authorizing documentation that grants me the ability 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.

14. 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 authorization and delegation pursuant to the power of attorney is a continuing one and will remain in effect in the event of the Account Owner's disability or incompetence, (3) the power of attorney remains in full force and effect and has not been withdrawn, amended or removed; and (4) the Account Owner is still living.

15. To the best of my knowledge, I certify under penalties of perjury that no other ABLE program Account exists for the benefit of the Account Owner, except in the case of a Rollover from another ABLE program. 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 amount was distributed from the other ABLE program Account. I acknowledge that failure to do so will result in my Account not being treated as an 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.

16. I agree to promptly inform Arkansas ABLE in the event that any of the foregoing certifications becomes untrue. I understand and acknowledge that Arkansas ABLE 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 Arkansas ABLE 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)*

SIGNATURE
Signature of Co-Authorized Individual listed in **Section 4** *(Only if applicable)*

☐☐—☐☐—☐☐☐☐
Date *(mm/dd/yyyy)*

11. Additional Information *(Optional)*

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

- ☐ Family/Friend
- ☐ Organization
- ☐ Employer
- ☐ School Event
- ☐ Arkansas ABLE Website
- ☐ Other
- ☐ Advisor
- ☐ Ad
- ☐ Email
- ☐ Magazine
- ☐ Mailing