



Dear Future Arkansas ABL Account Owner,

Thank you for your interest in the Arkansas ABL Plan! We're excited to be able to help you save for your current and future expenses. To open an Arkansas ABL Account you will need your full name, address, date of birth, social security number, and, if you opt to fund your Account through a bank, your bank account information.

Below is a table of documentation requirements, if any, when completing Section 3 of the Enrollment Form (if applicable).

Authorized Individual Type:	Typical Documentation:
All Authorized Individuals	There are no document requirements for the Arkansas ABL Plan.

If you have any questions, please call Arkansas ABL at 888-609-8874, Monday – Friday
7:00 am – 4:00 pm CT.

Thank you,

Arkansas ABL




Arkansas ABL Enrollment Form

IMPORTANT INFORMATION ABOUT OPENING A NEW ACCOUNT.

We are required by federal law to obtain and record, from each person or Entity who opens or assumes signature authority over an Account, certain personal information — including name, street address, social security or tax identification number and date of birth, among other information — that will be used to verify their identity. All required information must be provided in order to verify identity and open the Account.

- You can open an Account online at **arkansasable.com**.
- An individual may only have one ABL account nationwide.
- The Account may only be opened for an Eligible Individual.
- The Plan Disclosure Booklet contains important information about the Arkansas ABL Plan including, among other information, the objectives, risks, fees and restrictions associated with opening an Account and investing in the Arkansas ABL Plan.
- Capitalized terms used in this Enrollment Form, but not defined in this form, have the meanings provided in the Plan Disclosure Booklet.
- Accounts that are opened and not funded within 90 days will be permanently closed.
- Before investing, check with your home state to determine if it offers tax or other benefits for investing in its plan.
- Type or print clearly, printing in capital letters and black ink. Please mail or fax the form to the Arkansas ABL Plan. Do not staple.
- All sections of this form must be completed unless indicated otherwise.

Forms can be downloaded from our website at **arkansasable.com**, or you can call Customer Service to request 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.

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

FAX 1.617.559.8937

 **arkansasable.com**

 **clientservice@arkansasable.com**

Regular mailing address:

Arkansas ABL
P.O. Box 219092
Kansas City, MO 64121

Overnight mailing address:

Arkansas ABL
1001 E 101st Terrace, Suite 200
Kansas City, MO 64131

A. Please select the Account Owner's disability, which occurred prior to their 46th birthday:

Report only one primary code number for an Account Owner. If more than one code applies, select the most significant code. The following information is required by the federal government.

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, Xerodermic pigmentosum, Spinal muscular atrophy, Fragile X syndrome, Edwards syndrome
- Code 6** - Respiratory Disorders: Cystic Fibrosis
- Code 7** - Any other disability not listed under Codes 1 – 6, including but not limited to Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease, Hemophilia

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

To be eligible for an ABLE account, the Account Owner's disability must have begun before the age of 46. The Account Owner must also meet one of the requirements below. Refer to the Plan Disclosure Booklet for a full description of Account eligibility. Please select whichever statement applies best:

- The Account Owner is receiving SSDI (Social Security Disability Insurance) based on blindness or a disability.
- The Account Owner is receiving SSI (Supplemental Security Income) based on blindness or a disability; or, is entitled to receive SSI, but has had that entitlement suspended solely due to excess income or resources.
- The Account Owner's disability is identified on the Social Security Administration's List of Compassionate Allowances Conditions (see ssa.gov/compassionate allowances). 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, and 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 of 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, 416.924 and 416.926a. Refer to the Plan Disclosure Booklet for a full description.

Please select the age range that indicates the age of onset for the Account Owner's disability:

- Birth to 25 years old
- 26 to 45 years old

Optional checking account features

- (Optional) Check this box to receive a free debit card with the Checking Account Option. **Note:** For Accounts established by the Account Owner and Accounts where an Account Owner with Legal Capacity has designated an Authorized Individual as their agent under power of attorney, a debit card will be mailed to the Account Owner's mailing address within 10 calendar days after the Checking Account Option is funded. For Accounts established by an Authorized Individual for a minor or an adult without Legal Capacity, the debit card will be issued in the name of the Authorized Individual and mailed to the Authorized Individual's mailing address. Contributions into the Checking Account Option will be available for withdrawal after 6 or 7 business days.
- (Optional) Check this box to order checks. **Note:** For Accounts established by the Account Owner and Accounts where an Account Owner with Legal Capacity has designated an Authorized Individual as their agent under power of attorney, the checks will be issued in the name of the Account Owner and mailed to the Account Owner's mailing address. For Accounts established by an Authorized Individual for a minor or an adult without Legal Capacity, the checks will be issued in the name of the Account Owner and the Authorized Individual and mailed to the Authorized Individual's mailing address. A fee of \$6 will be assessed to the Checking Account Option. Checks will be shipped when the balance of the Checking Account Option is at least \$6.
- Separate statements for the Checking Account Option will be provided by Fifth Third Bank. To update statement delivery preferences for the Checking Account Option, please log onto www.53.com after the free debit card (if selected) or confirmation of the deposit has been received.
 - For Accounts managed by multiple Authorized Individuals for a minor or an adult without Legal Capacity, only one Authorized Individual will be permitted to access the checking account, write checks, and use the debit card if the Checking Account Option is selected. Note that the Plan may require submission of a separate release form or other instruments or documentation when an Account has multiple Authorized Individuals.

Information About the Arkansas ABL Plan Systematic Exchange Program

The Arkansas ABL Plan 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 program, please complete the **Account Financial Features Form** available online at arkansasable.com. If you want to establish a Systematic Exchange Program at the time of enrollment and not have it count toward the twice-per-calendar-year limit on changing Investment Options, you must complete the **Account Financial Features Form** and mail it together with this **Enrollment Form** to the Plan. Establishing a Systematic Exchange Program counts as an investment election if you do not establish it either at the time of enrollment or when making a contribution to the Account. See the Plan Disclosure Booklet for more information about the Systematic Exchange Program.

6. Contribution Method

- The minimum contribution amount is \$1.00. An Account may be opened without making an immediate contribution. However, a contribution must be made to the Account within 90 days of the date the Account is opened, or the Account will be permanently closed.
- Contributions to the Asset Allocation 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.

Note: The Account is subject to an Annual Contribution Limit. For more information read the Plan Disclosure Booklet, visit the Plan website, or contact Customer Service.

Source of funds (Check all that apply):

- A. **Check. Important:** All checks must be payable to the Arkansas ABLE Plan.

\$, .
Amount

- B. **Recurring contributions.** Check this box to set up the Account so contributions are automatically made on a regular basis from a bank, savings and loan, or credit union account. Money will be transferred into the 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 the Account at arkansasable.com or by calling Customer Service at **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 Arkansas ABLE Plan Account Owner or the Authorized Individual, complete an **Account Financial Features Form** available online at arkansasable.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; otherwise, this recurring contribution will begin on the following monthly or quarterly period indicated. If the date is not specified, this recurring contribution will begin on the 15th day of the month following the Plan's 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. **Direct Rollover or Indirect Rollover from another ABLE account to the Arkansas ABLE Plan.** You must complete the **Incoming Direct Rollover Form** for a Direct Rollover from another ABLE plan, or complete the **Incoming Indirect Rollover Form** for Indirect Rollovers from another ABLE plan. The form should be completed and mailed together with this **Enrollment Form**. Each form is available online at arkansasable.com, or by calling **1.888.609.8874**.
- F. **Direct Rollover or Indirect Rollover from a Section 529 Education Savings Plan to the Arkansas ABLE Plan.** You must complete the **Incoming Direct Rollover Form** for a Direct Rollover from a Section 529 Education Savings Plan, or complete the **Incoming Indirect Rollover Form** for an Indirect Rollover from a Section 529 Education Savings Plan 529. The form should be completed and mailed together with this **Enrollment Form**. Each form is available online at arkansasable.com, or by calling **1.888.609.8874**.

7. Bank Information. To electronically transfer funds by recurring contributions or EFT, the financial institution must be a member of the Automated Clearing House (ACH). Money market mutual funds and cash management accounts offered through non-bank financial companies cannot be used.

Important: By adding this account, you are acknowledging that the bank or financial institution is located in the U.S. and/or adheres to U.S. banking regulations.

Bank Name

Bank Routing Number

Bank Account Number

Account Type: (Check One) Checking Savings

Name(s) on Bank Account

Name (First, Middle Initial, Last) or Entity name

Name (First, Middle Initial, Last) or Entity name

If the bank account owner of the above account is not the same as the Arkansas ABLE Plan Account Owner or the Authorized Individual, the named bank account owner(s) must authorize the use of their bank account for the recurring contribution and/or EFT service by signing here:

Signature of bank account owner

Date (mm/dd/yyyy)

Signature of bank account owner

Date (mm/dd/yyyy)

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 Booklet (which includes the Plan Disclosure Statement and the Plan Addendum) 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 read, obtain an understanding of and 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, 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 the 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 receipt of this form or by 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 the 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 or their authorized agents will not incur any loss, liability, cost, or expense for acting upon the receipt of this form or 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 46.

- 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 46.
- 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**, which identifies 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 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, a 403(b) plan annuity plan, or a 457(b) deferred compensation 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 ABL 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 ABL 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 an Indirect Rollover or a Direct Rollover of its assets into this Account. If I am establishing this Account through an Indirect Rollover or a Direct Rollover from the Account Owner’s account in another ABLE program, for Indirect Rollovers, 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 and for Direct Rollovers, I agree to close the other account upon completion of the Direct Rollover. I acknowledge that failure to do so will result in this 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 transferring assets from another ABLE program by Indirect Rollover, I certify under penalties of perjury that there has not been an Indirect 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 and may result in tax liability or affect the Account Owner’s means-tested benefits) to the Account Owner, as applicable, if the Plan has reasonable grounds to believe that any of the foregoing certifications is untrue.

Account Owner Name OR Authorized Individual named in **Section 3** (First, Middle Initial, Last) or Entity name

Signature of Account Owner OR Authorized Individual, or Entity signatory

 - -

Date (mm/dd/yyyy)

9. Additional Information (Optional)

Where did you hear about us? (Select One)

- | | |
|--|--|
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Advisor |
| <input type="checkbox"/> Organization | <input type="checkbox"/> Ad |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Email |
| <input type="checkbox"/> School Event | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> Arkansas ABLE Website | <input type="checkbox"/> Mailing |
| <input type="checkbox"/> Special Olympics | <input type="checkbox"/> Center for Independent Living |
| <input type="checkbox"/> Veteran Organization | <input type="checkbox"/> Other |