

7. Change in eligibility basis

Please select the Account Owner's disability, the onset of which occurred prior to their 46th 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 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

INITIALS I certify under penalties of perjury that the applicable diagnostic code [i.e., Codes 1-7] provided above is accurate.

Basis under which ABLE eligibility is asserted: Refer to the Plan Disclosure Booklet for a full description of Account eligibility. Please select whichever statement applies best. (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/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. 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, 416.926a. Refer to the Plan Disclosure Booklet for a full description.

Read the certifications and initial the box below:

I certify under penalties of perjury that the Account Owner is blind (within the meaning of section 1614(a)(2) of the Social Security Act) or 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 further certify under penalties of perjury that the Account Owner's blindness or disability occurred before the Account Owner attained age 46.

11. Signature—YOU MUST SIGN BELOW

- By signing below, I certify that I have read and understand, consent to, and agree to all the terms and conditions of the Plan Disclosure Booklet as currently in effect and understand the rules and regulations as they relate to this information change request.
- If you are transferring ownership of the Account assets pursuant to **Section 4** of this Form, the former Account Owner’s or the former Account Owner’s Authorized Individual’s signature must be notarized in **Section 12**.
- Please note that if you are transferring ownership of the Account assets to a new Account Owner, the new Account Owner must be an Eligible Individual and for some Plans, a Sibling, as defined in the Plan Disclosure Booklet. An Account Owner may only have one ABLE account nationwide. You should carefully review the Plan Disclosure Booklet and ensure you fully understand the implications of transferring the ownership of Account assets.
- By signing below, I authorize the Program Manager or its designee to change the Account information according to the instructions in this form.
- If I am an Authorized Individual, I certify that I am authorized to act on behalf of the Account Owner in making this request.

Account Owner or Authorized Individual Name (First, Middle Initial, Last)

SIGNATURE
Signature of Account Owner or Authorized Individual

- -
Date (mm/dd/yyyy)

Additional Authorized Individual Name (First, Middle Initial, Last)

SIGNATURE
Signature of Additional Authorized Individual (Only if applicable)

- -
Date (mm/dd/yyyy)

12. Notary—REQUIRED FOR TRANSFERS TO A NEW ACCOUNT OWNER ONLY

If you are transferring ownership of the Account assets from a living Account Owner to another living Account Owner, the former Account Owner’s (as defined in Section 4) or the former Account Owner’s Authorized Individual’s signature must be notarized.

I certify that the information provided herein is true and complete in all respects, and that I have read and understand, consent, and agree to all the terms and conditions of the Arkansas ABLE Disclosure Booklet as currently in effect.

STATE OF _____)

COUNTY OF _____)

This document was acknowledged before me on _____ (date) by _____
(name of Account Owner or Authorized Individual who certifies the correctness of the signature of the Account Owner or Authorized Individual).

SIGNATURE
Signature of Notary

- -
Date (mm/dd/yyyy)

Name of Notary (First, Middle Initial, Last)

My commission expires:

- -
Date (mm/dd/yyyy)

Notary to place seal here

Applies to signature in **Section 11**.