



Arkansas ABL Withdrawal Request Form

- Use this form to request a full or partial withdrawal from your Arkansas ABL account. For withdrawals not used for Qualified Disability Expenses the earnings portion may be subject to federal and state income tax and an additional 10% federal tax. See the Arkansas ABL Disclosure Documents for more information.

Note: You can also request a withdrawal by telephone or online at ar.savewithable.com.

- We are required to file IRS Form 1099-QA if you take a withdrawal from your Arkansas ABL account.
- A recent contribution must be invested with Arkansas ABL for a period of 5 business days (*6 business days for checking option*) prior to withdrawal.
- A withdrawal cannot be made for 10 business days after the address on the account has changed.
- You are encouraged to retain receipts for expenses paid from your withdrawal.
- Type or print clearly, printing in capital letters and black ink. Please mail the form to the 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 8 a.m. to 5 p.m. ET.

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

Overnight mailing address:

Arkansas ABL
920 Main Street, Suite 900
Kansas City, MO 64105

1. Account information

—

Account Number

— —

Account Owner Social Security or Taxpayer Identification Number **(Required)**

Name of Account Owner (*first, middle initial, last*)

— —

Telephone Number



* AR ABLE WITHDRAW *

4. Signature — YOU MUST SIGN BELOW

- I certify that I have read, understand, consent, and agree to all terms and conditions of the Arkansas ABLE Disclosure Documents and understand the rules and regulations governing withdrawals from my Arkansas ABLE account. I also certify that the information provided on this form is accurate and hereby instruct Arkansas ABLE to distribute my account as I have indicated.
- By signing below, I authorize Arkansas ABLE or its designees to withdraw funds according to the instructions above. I understand that if I have changed my address or the Account Owner, I cannot withdraw funds for 10 business days after the change.
- I understand that the earnings portion of Non-Qualified Withdrawals is subject to federal and state income tax and an additional 10% federal tax. I also understand that I am responsible for reporting the withdrawal on my income tax returns for the tax year the Non-Qualified Withdrawal was made.
- I understand that if I had taken a state income tax deduction or credit on my state income taxes I will need to check with my home state to determine if my deduction or credit is subject to recapture.
- If I am an Authorized Individual, I certify that I am authorized to act on the Account Owner’s behalf in making this request and that this request is in the best interest of the Account Owner.

SIGNATURE

Signature of Account Owner or Authorized Individual

□□ — □□ — □□□□

Date (mm/dd/yyyy)

SIGNATURE

Signature of Co-Authorized Individual (Only if applicable)

□□ — □□ — □□□□

Date (mm/dd/yyyy)

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