DO NOT STAPLE

DC ABLE
National ABLE Alliance Member

DC ABLE

Account Information Change Form

- Use this form to: update existing Account Owner information, transfer Account ownership to a new Account Owner, update existing Authorized Individual information, add or change an email address, change eligibility basis, add or update a Successor Account Owner, add or update a Successor Authorized Individual, or add or update an Interested Party.
- If you are transferring Account ownership, of an existing Account of a living Account Owner, to another living Account Owner, your signature must be notarized in **Section 12**. The new Account Owner or Authorized Individual must also complete and submit an **Enrollment Form**. The new Account Owner must be an Eligible Individual and for some Plans, a Sibling, as defined in the Plan Disclosure Booklet. Eligible Individuals may only have one ABLE account nationwide. See the Plan Disclosure Booklet for additional information.
- If you are changing the Account Owner's legal name, you must provide a copy of an official document that changes the name. (i.e. marriage certificate, divorce decree, etc.)
- Type or print clearly, printing in capital letters and black ink. Please mail the form to the Plan. Do not staple.

1.888.609.3458
8 a.m. to 5 p.m. ET M-F

dc.savewithable.com

dc.clientservice@savewithable.com

Regular mailing address:
DC ABLE
P.O. Box 219235
Kansas City, MO 64121

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

Forms can be downloaded from our website at **dc.savewithable.com**, or you can call us to order any form — or request assistance in completing this form — at **1.888.609.3458** any business day from 8 a.m. to 5 p.m. ET.

1. Existing Account Owner information *(This section must be completed.)*

☐☐☐☐☐☐☐☐☐ – ☐☐
Account Number

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

☐☐☐ – ☐☐☐ – ☐☐☐☐
Telephone Number

2. Information to update or change *(Select all that apply.)*

☐ Update existing Account Owner information — **Section 3** and **11**
☐ Transfer Account to a new Account Owner — **Section 4, 11** and **12**
☐ Update Authorized Individual information — **Section 5**
☐ Add/Change Email Address — **Section 6**
☐ Change in eligibility basis — **Section 7**
☐ Add/Update Successor Account Owner — **Section 8**
☐ Add/Update Successor Authorized Individual — **Section 9**
☐ Add/Update Interested Party — **Section 10**

DC ABLE ACCT INFO CHANGE

3. Update existing Account Owner information

Use this section to change the legal name of an existing Account Owner (e.g. due to marriage or adoption) or to change the contact information of the existing Account Owner. Provide the new information exactly as you would like it to appear on the DC ABLE account. You do not need to enter information that will not be changed.

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

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

Telephone Number

4. Transfer Account to a new Account Owner

- Use this section to transfer Account ownership from an existing Account Owner, while living, to another living Account Owner. This will transfer ownership of all of the assets in the Account of the existing Account Owner in **Section 1** to the new Account Owner named below.
- If your Plan permits transfers of Account ownership to non-Sibling Eligible Individuals, it is important to understand that a non-Sibling transfer will be treated as a Non-Qualified Withdrawal by the former Account Owner and may generate negative consequences including tax liability, impacts to the current Account Owner's means-tested benefits, and potential limitations on investment direction for the new Account Owner. A non-Sibling transfer will also be subject to the Annual Contribution Limit and Account Balance Limit. Please carefully review the Plan Disclosure Booklet information on transferring Account ownership and the potential tax and benefits implications of making a Non-Qualified Withdrawal.
- To transfer Account ownership, a Notarized Signature must be added in **Section 12**.
- The new Account Owner or Authorized Individual must complete an **Enrollment Form if the new Account Owner does not already have a DC ABLE account**.

Please provide the following information for the new Account Owner.

Account Number *(If applicable)*

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

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

5. Update existing Authorized Individual information

Use this section to update information about an existing Authorized Individual. Use the separate Add an Authorized Individual Form to add a new Authorized Individual to the Account. The Account Mailing Address, provided below, will be used as the Account's address of record for all Account mailings.

Authorized Individual *(First name)* *(m.i.)*

Authorized Individual Legal Name *(Last name)*

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

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

Telephone Number

6. Add or Change Email Address

Complete this section to add or change the email address to which email communications are sent from the Plan, or to change the address used for E-Delivery for the Account. Entities (group homes, care providers, etc.) must provide a continuously monitored organizational email address that is not exclusively associated with a specific employee. ***Only one email address can be associated with the Account.***

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 at www.53.com/ABLE after the checking account is open.

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

Provide your email address below:

Email Address

7. Change in eligibility basis

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

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: *(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 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 keep a copy of the diagnosis. It 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 this section, 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.

INITIALS 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 26.

If I selected above 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 I selected above 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 I selected above 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 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.

8. Add/Update Successor Account Owner

- Complete this section to designate an Eligible Individual to assume ownership of the Account after the death of the Account Owner, or to replace or remove a current Successor Account Owner. The Successor Account Owner designation must be submitted and processed during the life of the Account Owner, even though the designation will not take effect until after the death of the Account Owner. There may only be one Successor Account Owner named on the Account. A transfer of the Account to a non-Sibling will be treated as a Non-Qualified Withdrawal by the former Account Owner and may have federal gift tax or GST tax implications. A non-Sibling transfer will also be subject to the Annual Contribution Limit, Account Balance Limit, and other consequences. In some cases, the Plan may not be able to carry out a transfer to a non-Sibling. See the Plan Disclosure Booklet for additional information related to Successor Account Owners.

Check one:

☐ Add ☐ Change ☐ Remove

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

Birth Date *(mm/dd/yyyy)*

Telephone Number

Mailing Address

City State Zip Code

Relationship:

☐ Sibling ☐ Non-Sibling

9. Add/Update Successor Authorized Individual

- Complete this section to designate a person or entity to succeed an existing Authorized Individual in the event of the removal, resignation, death, or incapacity of the Authorized Individual, or to replace or remove an existing Successor Authorized Individual. There may only be one Successor Authorized Individual designated on the Account. The Successor Authorized Individual must be able to meet all of the eligibility and priority requirements of an Authorized Individual. Please refer to the Plan Disclosure Booklet to determine who is eligible to serve as an Authorized Individual.

Check one:

☐ Add ☐ Change ☐ Remove

Name of Successor Authorized Individual *(first, middle initial, last)*

Birth Date *(mm/dd/yyyy)*

Telephone Number

Mailing Address

City State Zip Code

10. Add/Update Interested Party Information

- Complete this section to designate a person or entity as an Interested Party, to update information of an existing Interested Party or to replace/remove an Interested Party. An Interested Party receives duplicate Account statements and can access information about the Account by calling customer service. Please refer to the Plan Disclosure Booklet for more information on the role of an Interested Party.

Check one:

☐ Add ☐ Replace ☐ Change Current Information ☐ Remove

Name of Interested Party *(first, middle initial, last)*

Mailing Address

City State Zip Code

Telephone Number

11. Signature — YOU MUST SIGN BELOW

- I certify that I have read, understand, consent, and agree to all the terms and conditions of the DC ABLE Disclosure Booklet as currently in effect and understand the rules and regulations governing DC ABLE as they relate to this information change request.
- Please note that if you are transferring Account ownership 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 an Account.
- By signing below, I authorize the Program Manager or its designee to change the Account information according to the instructions above.
- If I am an Authorized Individual, I certify that I am authorized to act on behalf of the Account Owner in making this request.

SIGNATURE

Signature of Account Owner or Authorized Individual

Date *(mm/dd/yyyy)*

SIGNATURE

Signature of Additional Authorized Individual *(Only if applicable)*

Date *(mm/dd/yyyy)*

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

- Your 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 DC ABLE Disclosure Booklet as currently in effect.

STATE OF ______________________________)

)ss.:

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.**

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