



### 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 Minnesota ABLE Plan 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 Minnesota ABLE Plan 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](http://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, Xerodermic 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/compassionateallowances](http://ssa.gov/compassionateallowances)). 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.







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