



MONTANA ABLE

Montana ABLE

Age of Majority – Authorized Individual Retaining Authority Form

IMPORTANT INFORMATION ABOUT THIS ACCOUNT.

- This form can only be completed by the current Authorized Individual(s) who will be retaining authority to continue to act as Authorized Individual(s) when, after reaching the age of majority, the Account Owner does not have Legal Capacity to manage the Account.
- The Authorized Individual(s) retaining authority for the eligible adult who does not have Legal Capacity must be the highest ranking on the list of Authorized Individuals who is willing and able to act as Authorized Individual.
- Each Authorized Individual who will be retaining authority over the Account must complete Section 2 and 3 of this form.
- On the date the Account Owner reaches age of majority, withdrawals from the Account will be frozen until a completed and signed Age of Majority - Authorized Individual Retaining Authority Form is received by the Plan for Account Owners who lack Legal Capacity, or other Account Owner or new Authorized Individual take other actions.
- The Plan Disclosure Booklet contains important information about the Montana ABLE Plan including, among other information, the objectives, risks, fees and restrictions associated with opening an Account and investing in the Montana ABLE Plan.
- Capitalized terms used in this Age of Majority - Authorized Individual Retaining Authority Form, but not defined in this form, have the meanings provided in the Plan Disclosure Booklet.
- Type or print clearly, printing in capital letters and black ink. Please mail or fax the form to the Montana ABLE Plan. Do not staple.
- All sections of this form must be completed.

Forms can be downloaded from our website at **mt.savewithable.com**, or you can call Customer Service to request any form — or request assistance in completing this form — at **1.888.609.3461** any business day from 8 a.m. to 5 p.m. MT.

 **1.888.609.3461**
8 a.m. to 5 p.m. MT M-F

FAX 1.617.559.8932

 **mt.savewithable.com**

 **mt.clientservice@savewithable.com**

Regular mailing address:

Montana ABLE
P.O. Box 219234
Kansas City, MO 64121

Overnight mailing address:

Montana ABLE
1001 E 101st Terrace, Suite 200
Kansas City, MO 64131

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[illegible]

M.I.

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- -

Telephone Number

[illegible]

(M.I.)

[illegible]

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Telephone Number

2

Authorized Individual's Legal First Name																										(M.I.)	
Authorized Individual's Legal Last Name																											
			-			-										-											
Last 4 digits of Authorized Individuals Social Security Number												Telephone Number															

1. ☐ Conservator OR ☐ Legal Guardian 2. ☐ Spouse 3. ☐ Parent

4. ☐ Sibling 5. ☐ Grandparent 6. ☐ SSA-appointed Representative Payee

- I hereby certify under penalties of perjury that I am the above-selected Authorized Individual type and that any legal documentation provided by me is true and correct. (See the cover page for this form to determine what documentation, if any, the Plan requires to confirm the Authorized Individual's relationship to the Account Owner and authority to manage the Account on behalf of the Account Owner).
- I hereby certify under penalties of perjury that I am maintaining the Account for an eligible adult who lacks Legal Capacity as defined in the Plan Disclosure Booklet, no other person that is willing and able to act as Authorized Individual ranks higher on the above list of possible Authorized Individuals.
- I further certify under penalties of perjury that I will notify the Montana ABLE Plan if my authority expires or is removed.

If the Account utilizes the Checking Account Option now or in the future, I hereby acknowledge that I have received, read, and that by signing below, agree to the Fifth Third Terms and Conditions.

By signing this Age of Majority - Authorized Individual Retains Authority 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 form is accurate and complete.
- I certify, under penalties of perjury, I will review and confirm that the information previously provided regarding the Account Owner's disability, the Account Owner's status as an Eligible Individual, and the basis for the Account Owner's eligibility remains accurate and complete.
- 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 (1) I have the authority to continue to serve as the Account Owner's conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed for the Account Owner by the Social Security Administration, in that order of priority; and (2) no other person that is willing and able to serve as Authorized Individual for this Account ranks higher than I do 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), 403(b) plan, or 457(b) 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.
- 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 ABLE account for the Account Owner, including the ability to transact, and maintain a financial account on behalf of the Account Owner.
- I certify under penalties of perjury that I neither know nor have reason to know that the Account Owner already has another existing ABLE account.

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 result in a Non-Qualified Withdrawal) to the Account Owner, as applicable, if the Plan has reasonable grounds to believe that any of the foregoing certifications is untrue.

Authorized Individual A (First, Middle Initial, Last)

SIGNATURE Blue or Black Ink

Signature of Authorized Individual A

- -

Date (mm/dd/yyyy)

Authorized Individual B (First, Middle Initial, Last)

SIGNATURE Blue or Black Ink

Signature of Authorized Individual B

- -

Date (mm/dd/yyyy)