Dear Authorized Individual,

Thank you for your interest in the NC ABLE Program! We're excited that we are continuing to help you save for the Account Owner's current *and* future expenses. Complete the **Age of Majority – Authorized Individual Retaining Authority Form** if you are 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. If you are to continue managing the Account in your current capacity, no additional documentation is required. If you are certifying in Section 2A and/or Section 2B that you are now acting as one of the Authorized Individual(s) types below, please submit the corresponding documentation.

If you have any questions, please call NC ABLE Customer Service at (888) 627-7503 Monday - Friday, 8:00 am - 5:00 pm ET

Authorized Individual Type in order of priority	Documentation List
Conservator/Legal Guardian	Letters of appointment issued by a court, granting appropriate financial authority
SSA-appointed Representative Payee	The Selection Notice or Benefits Verification Letter issued by the Social Security Administration showing Authorized Individual as representative payee

NC ABLE PROGRAM

NC 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 NC ABLE Plan including, among other information, the objectives, risks, fees and restrictions associated with opening an Account and investing in the NC ABLE Plan.

1.888.627.7503
8 a.m. to 5 p.m. ET M-F

FAX **1.617.559.8925**

NCABLE.org

nc.clientservice@savewithable.com

Regular mailing address:
NC ABLE
P.O. Box 219350
Kansas City, MO 64121

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

- 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 NC ABLE Plan. Do not staple.
- All sections of this form must be completed.

Forms can be downloaded from our website at **NCABLE.org**, or you can call Customer Service to request any form — or request assistance in completing this form — at **1.888.627.7503** any business day from 8 a.m. to 5 p.m. ET.

1. Account Owner information

Account Number

Account Owner's Legal First Name M.I.

Account Owner's Legal Last Name

Last 4 Digits of Account Owner's Social Security Number

Telephone Number

2. Authorized Individual A

To be completed only by the current Authorized Individual(s) who will be retaining authority to continue to act as Authorized Individual(s) for the Account Owner.

For the purposes of this form, the Authorized Individual may only be the Account Owner's conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed by the Social Security Administration, in that order of priority.

- When multiple Authorized Individuals are named to an Account, it is the responsibility of the Authorized Individuals to manage the Account in accordance with any legal documentation, such as guardianship or conservatorship documents, that require the Authorized Individuals act together. If legal documentation requires Authorized Individuals to act together, it is the duty of the Authorized Individuals to reach agreement before either takes any action in managing and transacting on the Account. The Plan may require the submission of a separate release form or other instrument or documentation when an Account has multiple Authorized Individuals.

Authorized Individual A

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

I hereby certify under penalties of perjury that I am: (Select all that apply)

1. ☐ Conservator OR ☐ Legal Guardian
2. ☐ Spouse
3. ☐ Parent
4. ☐ Sibling
5. ☐ Grandparent
6. ☐ SSA-appointed Representative Payee

By signing **section 3** of this Authorized Individual Retains Authority at Age of Majority Form, the Authorized Individual is acknowledging the certifications below:

- 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 NC ABLE Plan if my authority expires or is removed.

Authorized Individual B

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

I hereby certify under penalties of perjury that I am: (Select all that apply)

1. ☐ Conservator OR ☐ Legal Guardian
2. ☐ Spouse
3. ☐ Parent
4. ☐ Sibling
5. ☐ Grandparent
6. ☐ SSA-appointed Representative Payee

By signing **section 3** of this Authorized Individual Retains Authority at Age of Majority Form, the Authorized Individual is acknowledging the certifications below:

- 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 NC ABLE Plan if my authority expires or is removed.

3. ACKNOWLEDGEMENTS, CERTIFICATIONS & SIGNATURE

I understand that by signing below, I hereby acknowledge that I have received, read, understand, and agree to the terms and conditions of the Plan Disclosure Booklet (which includes a Participation Agreement and the Fifth Third Terms and Conditions) as in effect on the date hereof which govern all aspects of this Account and are incorporated herein by reference. I will retain a copy of the Plan Disclosure Booklet for my records. Additionally, I agree to be bound by the terms and conditions of any Supplement or revision to the Plan Disclosure Booklet issued by the Plan during the time that I am an Authorized Individual. Capitalized terms that are used in this form, but not defined herein, have the meanings provided in the Plan Disclosure Booklet.

I acknowledge and agree that I am bound by the terms, rights, and responsibilities stated in the Plan Disclosure Booklet and this form and by any and all statutory, administrative, and operating procedures that govern the Plan. I understand that the Plan Disclosure Booklet, all subsequently added Supplements or revisions to the Plan Disclosure Booklet, the previously submitted Enrollment Form, and any subsequent forms signed by me constitute the entire agreement between me and the Plan.

I understand that with the exception of the Checking Account Option, investments are not guaranteed or insured by the FDIC or any other government agency and are not deposits or other obligations of any depository institution. The Checking Account Option is insured by the FDIC up to $250,000, subject to certain limitations. Contributions to and returns earned on Investment Options are not guaranteed or insured by the Plan Administrators and are subject to investment risks including the loss of the principal amount invested.

I understand that participation in the Plan does not guarantee that contributions and the investment return on contributions, if any, will be adequate to cover the Qualified Disability Expenses of the Account Owner.

I understand that there is no guarantee that the Plan will continue to meet the requirements of Section 529A of the Code or that the Account will continue to be eligible to receive the benefit of Section 529A or the ABLE Act.

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)