DO NOT STAPLE

RI's ABLE
Member of The National ABLE Alliance

Dear Future RI's ABLE Account Owner,

Thank you for your interest in the RI's ABLE Plan! We're excited to be able to help you save for your current and future expenses. To open a RI's ABLE Account, you will need your full name, address, date of birth, social security number, and, if you opt to fund your Account through a bank, your bank account information.

If you are an Authorized Individual acting for the Account Owner who is an eligible adult who has Legal Capacity you must provide a copy of the written Power of Attorney naming you as an attorney in fact, granting you the power to act on behalf of the Account Owner, and signed by the Account Owner or at the Account Owner's direction and notarized. A Power of Attorney Form is available at ri.savewithable.com. Required documentation is listed below.

Authorized Individual Type:	Typical Documentation:
Power of Attorney	Power of Attorney signed by the Account Owner and notarized

If you have any questions, please call RI's ABLE at 888-609-8915, Monday – Friday, 8:00 am – 5:00 pm ET.

Thank you,

RI's ABLE

RI's ABLE

RI's ABLE **Enrollment Form**

IMPORTANT INFORMATION ABOUT OPENING A NEW ACCOUNT.

We are required by federal law to obtain from each person who opens an Account certain personal information — including name, street address, and date of birth, among other information — that will be used to verify their identity. If you do not provide us with this information, we will not be able to open your Account. If we are unable to verify your identity, we reserve the right to close your Account or take other steps we deem reasonable.

1.888.609.8915
8 a.m. to 5 p.m. ET M-F

FAX **1.617.559.8926**

ri.savewithable.com

ri.clientservice@savewithable.com

Regular mailing address:
RI's ABLE
P.O. Box 219603
Kansas City, MO 64121

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

- You can enroll online at **ri.savewithable.com**.
- An individual can only have one ABLE Account nationwide.
- The Account can only be opened for an Eligible Individual.
- The Plan Disclosure Booklet contains important information about the RI's ABLE Plan including, among other information, the objectives, risks, fees and restrictions associated with opening an Account and investing in the RI's ABLE Plan.
- Capitalized terms used in this Enrollment Form, but not defined in this form, have the meanings provided in the Plan Disclosure Booklet.
- Accounts that are enrolled in good order and not funded within 90 days will be permanently closed
- Before investing, you should check with your home State to determine if it offers tax or other benefits for investing in its own plan.
- Type or print clearly, printing in capital letters and black ink. Please mail the form to the RI's ABLE Plan. Do not staple.
- All Sections of this form must be completed unless indicated otherwise.

Forms can be downloaded from our website at **ri.savewithable.com**, or you can call Customer Service to request any form — or request assistance in completing this form — at **1.888.609.8915** any business day from 8 a.m. to 5 p.m. ET.

1. Account Type

Check one:

- ☐ I am opening the Account for myself.
- ☐ I am opening the Account as a person, or as a representative of an entity, with authority to open the Account for an eligible minor.
- ☐ I am opening the Account as a person, or as a representative of an entity, with authority to open the Account for an eligible adult who has Legal Capacity as defined in the Plan Disclosure Booklet. (To check this box, the Account Owner must have designated you or your organization as an agent under power of attorney. You must retain the power of attorney with your records. To determine whether a copy of the power of attorney is required to be submitted with this **Enrollment Form**, see the cover page of this form. A Power of Attorney Form is available at **ri.savewithable.com**.
- ☐ I am opening the Account as a person, or as a representative of an entity, with authority to open the Account for an eligible adult who does not have Legal Capacity as defined in the Plan Disclosure Booklet.

2. Account Owner Information

The Account Owner is the Eligible Individual with the disability who owns the Account and whose Qualified Disability Expenses will be paid from the Account. (**All information in this section is required**).

Account Owner's Legal First Name (M.I.)

Account Owner's Legal Last Name

Social Security Number or Taxpayer Identification Number

Birth Date (mm/dd/yyyy)

Citizenship (If other than U.S. citizen, please indicate country of citizenship.)

Telephone Number

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, unless an Authorized Individual's address is provided in **Section 3** for this purpose.)

City State Zip Code

A. Account Owner's identity verification. (Required for an Account Owner who is an adult. This is not required for minors).

Note: To help the government prevent the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an Account.

- ☐ Check this box if the adult Account Owner does not have a driver's license, state-issued I.D., military I.D., or passport . By checking this box you acknowledge that the Account Owner will not be eligible to invest in the Checking Account Option.

Account Owner's driver's license, state-issued I.D. card, military I.D., or passport number (7-15 digits) State Expiration date (mm/dd/yyyy)

Please check one: ☐ Driver's license ☐ State-issued I.D. ☐ Military I.D. ☐ Passport

Passport country of issue

Account Owner's mother's maiden name

B. Please select the Account Owner's disability, which occurred prior to their 26th birthday:
(The following information is required by the federal government. Report only one primary code number for an Account Owner. If more than one code applies, select the most significant code.)

Note: Please DO NOT submit your written disability-related diagnosis or any protected health information (PHI). If we receive any PHI,we will destroy it using secure means. For any additional questions please contact the RI's ABLE Plan at 1.888.609.8915.

- ☐ **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

C. Basis under which ABLE eligibility is asserted: (Select only one)

To be eligible for an ABLE account, the Account Owner's disability must have begun before the age of 26. The Account Owner must also meet one of the requirements below. Refer to the Plan Disclosure Booklet for a full description of Account eligibility. Please select whichever statement applies best:

- ☐ The Account Owner is receiving SSDI (Social Security Disability Insurance) based on a disability.
- ☐ The Account Owner is receiving or is entitled to receive SSI (Supplemental Security Income) based on a disability, but has had that entitlement suspended solely due to excess income or resources.
- ☐ The Account Owner's disability is identified on the Social Security Administration's List of Compassionate Allowances Conditions (see 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 will keep a copy of the diagnosis that 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 ABLE eligibility, 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 of 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, 416.924 and 416.926a. Refer to the Plan Disclosure Booklet for a full description.

3. Authorized Individual

To be completed by the person, or by an authorized representative of an entity in the name of the entity, who is opening the Account as an Authorized Individual. Do not complete this section if you are opening the Account for yourself.

The Authorized Individual is the person or entity that can transact on the Account on behalf of the Account Owner. The Authorized Individual may be any person or entity selected by an Account owner with Legal Capacity, or the Account Owner's agent under a power of attorney, or, if none, a conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed by the Social Security Administration, in that order of priority.

For Entities: Provide the name of the entity in the First or Last Name boxes. Provide the entity's taxpayer identification number. Leave the birth date and citizenship boxes blank. Include the telephone number, street and mailing address of the entity. Please contact the RI's ABLE Plan for more information.

- An Account can have more than one Authorized Individual; however, all Authorized Individuals must be at the same priority level on the list of possible Authorized Individuals. An additional Authorized Individual can be added by completing the Add an Authorized Individual Form available online at **ri.savewithable.com**.
- If multiple Authorized Individuals are named, it is the responsibility of the Authorized Individuals to manage the Account in accordance with any legal documentation, such as guardianship or conservatorship documents or powers of attorney, 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.
- There is additional important information in **Section 5** about use of the Checking Account Option for Accounts that have Authorized Individuals.

Authorized Individual's Legal First Name (M.I.)

Authorized Individual's Legal Last Name

Social Security Number or Taxpayer Identification Number

Birth Date (mm/dd/yyyy)

Citizenship (If other than U.S. citizen, please indicate country of citizenship.)

Telephone Number

☐ Check if permanent street address is the same as the Account Owner's permanent street address, otherwise complete the following:

Permanent Street Address (P.O. boxes are **not** acceptable.)

City State Zip Code

Account Mailing Address

Complete this section for Accounts established by an Authorized Individual for a minor or for an adult without Legal Capacity. For these Accounts, the Authorized Individual will receive Account statements, transaction confirmations, tax forms and other Account-related correspondence.

This section should also be completed for Accounts where an Account Owner with Legal Capacity has designated an Authorized Individual. The Authorized Individual will receive duplicate Account statements and tax forms at the address designated below.

☐ Check if mailing address is the same as the permanent street address.

Account Mailing Address if different from above (The mailing address indicated here will be used as the Authorized Individual's address of record for all Account mailings.)

City State Zip Code

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

1. ☐ Power of Attorney 2. ☐ Conservator OR ☐ Legal Guardian 3. ☐ Spouse 4. ☐ Parent

5. ☐ Sibling 6. ☐ Grandparent 7. ☐ SSA-appointed Representative Payee

Read the certifications and initial the box below:

INITIALS

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 if I am opening the Account for an eligible minor or an eligible adult who lacks Legal Capacity as defined in the Plan Disclosure Booklet, no other person or entity that is willing and able to act as Authorized Individual ranks higher on the above list of possible Authorized Individuals.

I hereby certify under penalties of perjury that if I am being designated as an Authorized Individual by an eligible adult who has Legal Capacity, I am the person or representative of the entity appointed by the Eligible Individual pursuant to a valid power of attorney to open and manage the Account on their behalf.

I further certify under penalties of perjury that I will notify the RI's ABLE Plan if my authority expires or is removed.

Authorized Individual's Identity Verification. (Required)

Note: To help the government prevent the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an Account. Acceptable forms of identification include driver's license, state-issued I.D., military I.D., or passport.

☐ Check this box if the Authorized Individual does not have a driver's license, state-issued I.D., military I.D., or passport. By checking this box you acknowledge that the Authorized Individual will not be able to select the Checking Account Option for the Account.

Authorized Individual driver's license, state-issued I.D. card, military I.D., or passport number (7-15 digits) | State | Expiration date (mm/dd/yyyy)

Please check one: ☐ Driver's license ☐ State-issued I.D. ☐ Military I.D. ☐ Passport

Passport country of issue

Authorized Individual's mother's maiden name

4. Email Address and E-Delivery

Only one email address can be associated with the Account.

By providing an email address below you may receive email communications from the Plan related to the Account.

However, providing an email address here does not establish E-Delivery.

To establish E-Delivery, visit the Plan website after the Account is opened, and use the email address provided below. By establishing E-Delivery, the Annual Account Maintenance Fee will be reduced. If the Checking Account Option is selected, electronic statement delivery of monthly checking account statements must be established separately at www.53.com/ABLE after the checking account is open and the free debit card) or confirmation of deposit has been received.

IMPORTANT: Entities (organizations, agencies, companies) must provide a continuously monitored organizational email address that is not exclusively associated with a specific employee.

Provide your email address below:

Email Address

5. Investment Option Selection

- Before choosing your Investment Option(s), please read the Plan Disclosure Booklet, available at **ri.savewithable.com**, which contains important information about the Investment Options.
- Please select one or more Investment Options from the choices below and indicate how much you would like to allocate to each option.
- Please make sure to use whole percentages only and ensure that your total selection equals 100%.
- You do not have to select every option.
- If you choose only one Investment Option, please indicate 100% next to that option.
- Important Note for Entities: Entities may not select the Checking Account Option unless they are opening the Account as agent under a power of attorney designated by an Account Owner with Legal Capacity.

Aggressive Option	☐☐☐ %
Moderately Aggressive Option	☐☐☐ %
Growth Option	☐☐☐ %
Moderate Option	☐☐☐ %
Moderately Conservative Option	☐☐☐ %
Conservative Option	☐☐☐ %
Money Market Option	☐☐☐ %
Checking Account Option	☐☐☐ %
Total	**1 0 0 %**

Information about the Checking Account Option

☐ (Optional) Check this box to receive a free debit card with the Checking Account Option. Note: For Accounts established by the Account Owner and Accounts where an Account Owner with Legal Capacity has designated an Authorized Individual as their agent under power of attorney, a debit card will be mailed to the Account Owner's mailing address within 10 calendar days after the Checking Account Option is funded. For Accounts established by an Authorized Individual for a minor or an adult without Legal Capacity, the debit card will be issued in the name of the Authorized Individual and mailed to the Authorized Individual's mailing address. Contributions into the Checking Account Option will be available for withdrawal after 6 or 7 business days.

☐ (Optional) Check this box to order checks. **Note:** For Accounts established by the Account Owner and Accounts where an Account Owner with Legal Capacity has designated an Authorized Individual as their agent under power of attorney, the checks will be issued in the name of the Account Owner and mailed to the Account Owner's mailing address. For Accounts established by an Authorized Individual for a minor or an adult without Legal Capacity, the checks will be issued in the name of the Account Owner and the Authorized Individual and mailed to the Authorized Individual's mailing address. A fee of $6 will be assessed to the Checking Account Option. Checks will be shipped when the balance of the Checking Account Option is at least $25.

- Separate statements for the Checking Account Option will be provided by Fifth Third Bank. To update statement delivery preferences for the Checking Account Option, please log onto www.53.com/ABLE after the free debit card (if selected) or confirmation of the deposit has been received.
- For Accounts managed by multiple Authorized Individuals for a minor or an adult without Legal Capacity, only one Authorized Individual will be permitted to access the checking account, write checks, and use the debit card if the Checking Account Option is selected. Note that the Plan may require submission of a separate release form or other instruments or documentation when an Account has multiple Authorized Individuals.

Information About the RI's ABLE Plan Systematic Exchange Program

The RI's ABLE Plan offers a Systematic Exchange Program. A Systematic Exchange Program is a method of automatically moving money from one Investment Option to another Investment Option. If you are interested in participating in this program, please complete the **Account Financial Features Form** available online at **ri.savewithable.com**. If you want to establish a Systematic Exchange Program at the time of enrollment and not have it count toward the twice-per-calendar-year limit on changing Investment Options, you must complete the **Account Financial Features Form** and mail it together with this **Enrollment Form** to the Plan. Establishing a Systematic Exchange Program counts as an investment election if you do not establish it either at the time of enrollment or when making a contribution to the Account. See the Plan Disclosure Booklet for more information about the Systematic Exchange Program.

6. Contribution Method

- At least one contribution method is required
- Your initial contribution can come from several sources, but you must check at least one source. If you combine sources, check the appropriate box for each source and write in the contribution amount for each.
- Contributions to the Target Risk Options will be held for 5 or 6 business days before becoming available for withdrawal and contributions to the Checking Account Option will be held for 6 or 7 business days before becoming available for withdrawal.

Note: The Account is subject to an Annual Contribution Limit. For more information read the Plan Disclosure Booklet, visit the Plan website, or contact Customer Service.

Source of funds (Check all that apply.):

A. ☐ **Check. Important:** All checks must be payable to the RI's ABLE Plan.

$☐☐,☐☐☐,☐☐
Amount

B. ☐ **Recurring contributions.** Check this box to set up the Account so contributions are automatically made on a regular basis from a bank, savings and loan, or credit union account. Money will be transferred into the **RI's ABLE Plan Account** electronically based on the frequency indicated below. You may change the amount and/or frequency at any time by logging into the Account at **ri.savewithable.com** or by calling Customer Service at **1.888.609.8915**. Account Owners, family members, and friends can all contribute to the **RI's ABLE Plan Account** through recurring contributions. To add additional recurring contribution instructions or multiple bank accounts, attach a separate page with the information requested in **Sections 6B and 7** for each additional recurring contribution instruction or bank account.

Important: To set up this option, you must provide bank information in **Section 7**. If the bank account owner is not the same as the **RI's ABLE Plan Account** Owner or the Authorized Individual, complete an **Account Financial Features Form** available online at **ri.savewithable.com**.

Amount of Debit: ☐ $25 ☐ $50 ☐ $100 ☐ $150 ☐ Other **$**☐☐,☐☐☐,☐☐
Amount

Frequency (Check One)**:** ☐ Monthly ☐ Quarterly (Every three months)

Start Date:* ☐☐ — ☐☐ — ☐☐☐☐
Date (mm/dd/yyyy)

*The RI's ABLE Plan must receive instructions at least 3 business days prior to the start date specified; otherwise, this recurring contribution will begin on the following monthly or quarterly period indicated. If the date is not specified, this recurring contribution will begin on the 15th day of the month following the Plan's receipt of the request.

C. ☐ **Payroll Direct Deposit.** If you want to make contributions to the RI's ABLE Plan Account directly from a paycheck, first contact your employer's payroll office to verify that you can participate. After verifying, please complete and sign a **Payroll Direct Deposit Form** and submit to the RI's ABLE Plan. The RI's ABLE Plan will send you a **Payroll Direct Deposit Confirmation Form** to complete and submit to your employer's payroll office.

D. ☐ **Electronic Fund Transfer (EFT).** Through EFT, you can make contributions online at any time or by phone during normal business hours by transferring money from a bank account. We will keep the bank information on file for future EFT contributions. To set this up, you must provide bank information in **Section 7**. (The amount below will be a one-time EFT contribution to open the Account.)

$☐☐,☐☐☐,☐☐
Amount

E. ☐ **Direct Rollover or Indirect Rollover from another ABLE account to the RI's ABLE Plan.** You must complete the Incoming Direct Rollover Form for a Direct Rollover from another ABLE plan, or complete the **Additional Contribution/Indirect Rollover Contribution Form** for Indirect Rollovers from another ABLE plan. The form should be completed and mailed together with this Enrollment Form. Each form is available online at **ri.savewithable.com**, or by calling **1.888.609.8915**.

F. ☐ **Direct Rollover or Indirect Rollover from a College 529 Plan to the RI's ABLE Plan.** You must complete the **Incoming Direct Rollover Form** for a Direct Rollover from a College 529 Plan, or complete the **Additional Contribution/Indirect Rollover Contribution Form** for an indirect Rollover from a College 529 Plan. The form should be completed and mailed together with this Enrollment Form. Each form is available online at **ri.savewithable.com**, or by calling **1.888.609.8915**.

7. Bank Information. To electronically transfer funds by recurring contributions or EFT, your financial institution must be a member of the Automated Clearing House (ACH). If the bank account owner is not the same as the RI's ABLE Plan Account Owner or the Authorized Individual, complete an **Account Financial Features Form** available online at **ri.savewithable.com**. Money market mutual funds and cash management accounts offered through non-bank financial companies cannot be used.

Important: By adding this account, you are acknowledging that the bank or financial institution is located in the U.S. and/or adheres to U.S. banking regulations.

Bank Name

Bank Routing Number

Bank Account Number

Account Type: (Check One) ☐ Checking ☐ Savings

Name(s) on Bank Account

Name (First, Middle Initial, Last, or Entity name)

Name (First, Middle Initial, Last)

8. 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 the Plan Disclosure Statement and the Plan Addendum) 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 read, obtain an understanding of and 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 Account Owner or Authorized Individual. Capitalized terms that are used in this Enrollment 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 Enrollment 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, Enrollment Form and any subsequent forms signed by me constitute the entire agreement between me and the Plan. No person is authorized to make an oral modification to this agreement.

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 I am selecting the Checking Account Option, I hereby acknowledge that I have received, read, and that by signing below, agree to the Fifth Third Terms and Conditions.

If I have chosen the recurring contributions or EFT option, I authorize the Plan and its designees, upon receipt of this form or by telephone or online request, to pay amounts representing redemptions made by me or to secure payment of amounts invested by me, by initiating credit or debit entries to the account at the bank named on this Enrollment Form. I authorize the bank to accept any such credits or debits to the account without responsibility to their correctness. I acknowledge that the origination of ACH transactions involving the bank account named on this Enrollment Form must comply with U.S. law. I further agree that the Plan Administrators or their authorized agents will not incur any loss, liability, cost, or expense for acting upon the receipt of this form or my telephone or online request. I understand that this authorization may be terminated by me at any time by notifying the Plan and the bank by telephone or in writing, and that the termination request will be effective as soon as the Plan and the bank have had a reasonable amount of time to act upon it. I certify that I have authority to transact on the bank account identified by me on this Enrollment Form.

By signing this Enrollment 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 Enrollment Form is accurate and complete,including without limitation, the information regarding the Account Owner's disability, the Account Owner's status as an Eligible Individual, and the basis for the Account Owner's eligibility.
- 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:
  A. the Account Owner is blind (within the meaning of section 1614(a)(2) of the Social Security Act); or
  B. the Account Owner 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 certify under penalties of perjury that the Account Owner's blindness or disability occurred before the Account Owner attained age 26.

- If, on this Enrollment Form, I selected 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, on this Enrollment Form, I selected 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 on this Enrollment Form, I selected 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 the applicable diagnostic code (i.e., Codes 1-7), requested on this Enrollment Form, which identifies the type of the individual's impairment has been provided and is accurate.

- I certify under penalties of perjury that: (1) I am establishing the Account for myself as the Eligible Individual, or I am the person, or representative of the entity, selected by the Eligible Individual to establish the Account on their behalf, or if the Eligible Individual is unable to establish the Account, I have, or the entity that I represent has, the authority to establish the Account as the Eligible Individual's agent under a power of attorney, or if none, conservator or legal guardian, spouse, parent, sibling, grandparent, or representative payee appointed for the Eligible Individual by the Social Security Administration, in that order of priority; and (2) no other person or entity that is willing and able to establish this Account ranks higher than I do or the entity that I represent does 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 annual federal gift tax exclusion amount ($18,000 for 2024, increasing to $19,000 on January 1, 2025), 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, a 403(b) plan annuity plan, or a 457(b) deferred compensation 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.

- If I am establishing the Account for myself, I certify under penalties of perjury that I am of legal age in my state of residence and have the Legal Capacity to establish or manage an Account.

- If I am establishing the Account for an eligible minor, I certify under penalties of perjury that I am of legal age in my state of residence and that I am either the parent of the Account Owner or a person with appropriate authorization to manage an ABLE account for the Account Owner, including the ability to open, transact, and maintain an Account on behalf of the Account Owner.

- If I am opening the Account as the Authorized Individual for an adult who a) lacks the Legal Capacity to establish or manage an Account, or b) has Legal Capacity to establish or manage an Account and has granted me power of attorney, 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 open, transact, and maintain a financial account on behalf of the Account Owner.

- If I am opening the Account as the Authorized Individual for an adult who has granted me power of attorney, I certify under penalties of perjury that (1) the Account Owner was able and competent at the time the power of attorney was executed, (2) the power of attorney remains in full force and effect and has not been withdrawn, amended or removed, and (3) the Account Owner is still living.

- I certify under penalties of perjury that I neither know, nor have reason to know, that the Account Owner already has an existing ABLE account, other than an ABLE account that will terminate via an Indirect Rollover or a Direct Rollover of its assets into this Account. If I am establishing this Account through an Indirect Rollover or a Direct Rollover from the Account Owner's account in another ABLE program, for Indirect Rollovers, I agree to close the other account no later than the 60th day after the entire account balance was distributed from the other ABLE account and for Direct Rollovers, I agree to close the other account upon completion of the Direct Rollover. I acknowledge that failure to do so will result in this Account not being treated as an ABLE account. The consequences of an account not being treated as an ABLE account include loss of favorable tax treatment and possible loss of eligibility for resource-based benefits such as SSI and Medicaid.
- If I am transferring assets from another ABLE program by Indirect Rollover, I certify under penalties of perjury that there has not been an Indirect Rollover for the benefit of the Account Owner during the prior 12-month period.

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 be a Non-Qualified Withdrawal and may result in tax liability or affect the Account Owner's means-tested benefits) to the Account Owner, as applicable, if the Plan has reasonable grounds to believe that any of the foregoing certifications is untrue.

Account Owner Name OR Authorized Individual named in **Section 3** (First, Middle Initial, Last)

SIGNATURE

Signature of Account Owner OR Authorized Individual named in **Section 3**

Date (mm/dd/yyyy)

9. Additional Information (Optional)

How did you hear about the RI's ABLE Plan? (Select One)

- ☐ Family/Friend
- ☐ Organization
- ☐ Employer
- ☐ School Event
- ☐ RI's ABLE Website
- ☐ Special Olympics
- ☐ Veteran Organization
- ☐ Advisor
- ☐ Ad
- ☐ Email
- ☐ Magazine
- ☐ Mailing
- ☐ Center for Independent Living
- ☐ Other