



**Important information about opening a new account:**

- Before completing this form, carefully read the **Plan Disclosure and Participation Agreement**.
- An eligible person can only have one ABLE account open at any time.
- Fill out all sections of this form to open a new Washington State ABLE Savings Plan account.
- You'll need to make an initial contribution of at least \$25 to start off the account.
- If you connect a bank account to the ABLE account, the name of the Beneficiary or the Authorized Legal Representative must be associated with the bank account.
- Type or print clearly in black ink, and do not staple the pages or check.
- See the Plan Disclosure and Participation Agreement for the current yearly standard contribution limit.
- If you're making an ABLE to Work contribution, you may contribute an amount equal to the Beneficiary's gross income (see Program Disclosure Booklet for current limits) in addition to the yearly standard contribution limit.

**Need help?**

Give us a call Monday – Friday from 9am – 5pm PT at **1-844-600-2253**

Individuals with speech or hearing disabilities may dial 711 to access Telecommunications Relay Service (TRS) from a telephone or TTY.

**Mail the form to:**

Washington State ABLE Savings Plan  
P.O. Box 534431  
Pittsburgh, PA 15253- 4431

**Overnight Mail:**

Washington State ABLE Savings Plan  
Attention: 534431  
500 Ross Street, 154-0520  
Pittsburgh, PA 15262

**Fax:**

833-286-8171

**Want to enroll faster?**

Go online to [WashingtonStateABLE.com](http://WashingtonStateABLE.com)

**1 Is this a rollover from another ABLE plan?**

- Yes** (Please also fill out one of the applicable **Rollover Forms** in addition to this form. You can find forms at [www.WashingtonStateABLE.com/forms](http://www.WashingtonStateABLE.com/forms))
- No**

**2 Beneficiary information**

\_\_\_\_\_  
**Name** (First and last)

\_\_\_ / \_\_\_ / \_\_\_\_\_  
**Date** (mm/dd/yyyy)

**How does the beneficiary identify?**     As she     As he     Chooses not to identify



continued from page 1

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Social Security or Taxpayer Identification Number**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Telephone number**

**Residential address**

No PO boxes are accepted for a residential address.

\_\_\_\_\_  
**Street address 1**

\_\_\_\_\_  
**Street address 2**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
**Zip Code**

Does the Beneficiary self-identify as a veteran?  Yes  No

Are you an Authorized Legal Representative? If so, please complete **Step 3**.  
If not, disregard **Step 3** and move on to **Step 4**.



**3 Authorized Legal Representative information — If applicable**

\_\_\_\_\_  
**Name** (First and last)

**Relationship to the Beneficiary** (Please select one)

I certify under the penalties of perjury that I am the Beneficiary's:

- Power of Attorney**  
I have the Power of Attorney to open and manage an ABLE account for the Beneficiary.
- Parent**  
I have the authority to open and manage an ABLE account for the Beneficiary.
- Legal Guardian**  
The Beneficiary does not have a Power of Attorney pertaining to this ABLE account, and I am their legal guardian.
- Sibling**  
I have the authority to open and manage an ABLE account for the Beneficiary.
- Conservator**  
The Beneficiary does not have a Power of Attorney pertaining to this ABLE account, and I have been appointed conservator.
- Grandparent**  
I have the authority to open and manage an ABLE account for the Beneficiary.
- Spouse**  
I have the authority to open and manage an ABLE account for the Beneficiary.
- Representative Payee**  
I have the authority to open and manage an ABLE account for the Beneficiary.

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date of birth** (mm/dd/yyyy)

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
**Beneficiary's Social Security or Taxpayer Identification Number**

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
**Telephone Number**

**Residential address**

No PO boxes are accepted for a residential address.

- Authorized Legal Representative has the same address as the Beneficiary  
(Leave address information below blank)

\_\_\_\_\_  
**Street address 1**

\_\_\_\_\_  
**Street address 2**

\_\_\_\_\_  
**City**

\_\_\_\_-\_\_\_\_-\_\_\_\_\_  
**State      Zip Code**



**4** Communication preferences

Mailing address

PO boxes are accepted for a mailing address.

- Use the Beneficiary’s residential address as the mailing address  
(Leave address information below blank)
- Use the Authorized Legal Representative’s residential address as the mailing address  
(Leave address information below blank)

\_\_\_\_\_  
Street address 1

\_\_\_\_\_  
Street address 2

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Zip Code

**Choose how you want to receive statements and tax forms for all the accounts you manage**

(Please select one)

- Send digital tax forms, account information and quarterly statements by email  
(Please answer **Step 4A** below)
- Send digital quarterly statements and account information by email, but send tax forms by U.S. mail\*  
(Please answer **Step 4A** below)
- Send quarterly statements, account information and tax forms by U.S. mail\*  
(You’ll be charged \$10 per account, per year)

**A** What email address should we use?

Answer if you’ve chosen to receive items by email

\_\_\_\_\_  
Email

Want an easier way to enroll?  
Go online to [www.WashingtonStateABLE.com](http://www.WashingtonStateABLE.com) and use your email to set up an account.

\* All documents sent by U.S. mail will be mailed to the account’s mailing address.



**5** **Diagnosis Information**

This information is needed to confirm the Beneficiary's eligibility for the ABLE program.

**Which option applies to the Beneficiary?** (Please select one)

I certify under the penalties of perjury that:

- The Beneficiary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act
- The Beneficiary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act
- The Beneficiary
  - a. has a medically determinable physical or mental impairment that results in marked and severe functional limitation\* and can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; OR is blind†

AND

- b. has a signed diagnosis (see our **Physician's Form**) from a licensed physician‡ as to the condition described in (a)

I understand that I am required to retain such signed diagnosis and to provide it to the Program or the IRS upon request, and I agree to do so.

\* I understand that "marked and severe functional limitation" means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the "Listing"), but without regard to age. The Listing can be found at <https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1>. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary's prescribed treatment.

† I understand that, for purposes of eligibility for an ABLE account, "blind" means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at [https://www.ssa.gov/OP\\_Home/cfr20/404/404-app-p01.htm](https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm).



continued from page 5

**Diagnosis Code** (Please select one)

- Code 1: Developmental Disorder**  
Autistic Spectrum Disorder, Asperger's Disorder, Developmental Delays and Learning Disabilities
- Code 2: Intellectual Disability**  
Mild, moderate, or severe intellectual disability
- Code 3: Psychiatric Disorder**  
Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD), Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD) and Bipolar disorder
- Code 4: Nervous Disorder**  
Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington's disease, Multiple sclerosis, Severe sensorineural hearing loss and Congenital cataracts
- Code 5: Congenital Anomalies**  
Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum, Spinal muscular atrophy, Fragile X syndrome and Edwards syndrome
- Code 6: Respiratory Disorder**  
Cystic Fibrosis
- Code 7: Other**  
Anything not listed under codes 1-6 and Tetralogy of Fallot, Hypoplastic left heart syndrome, End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease and Hemophilia

**Is this disability permanent\*?**  Yes  No

I certify under the penalties of perjury that:

- The Beneficiary developed the disability or blindness before the age of 26
- The Beneficiary has no other ABLE account
- I will notify the Program of any changes to the permanence\* of the Beneficiary's disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence

\* Permanent/permanence is intended to mean a disability that "can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" as set forth in Section 529A of the Internal Revenue Code.



**6 Work Information**

Providing employment information will help us understand how the account is being funded.

**What is the Beneficiary or Authorized Legal Representative's work status?** (Please select one)

- Employed   
  Self-Employed   
  Retired or Not Working

**A**

What's your occupation (Please select one)  
Answer if **employed** or **self-employed**:

- |   |  |
|---|--|
| <input type="radio"/> Accounting/Auditing           | <input type="radio"/> Hospitality/Food           |
| <input type="radio"/> Admin/Clerical                | <input type="radio"/> Independent Investor       |
| <input type="radio"/> Art/Antiques Dealer           | <input type="radio"/> Information Technology     |
| <input type="radio"/> Banking Professional          | <input type="radio"/> Insurance                  |
| <input type="radio"/> Cannabis related business     | <input type="radio"/> Legal Services             |
| <input type="radio"/> Car/Boat/Airplane Dealer      | <input type="radio"/> Manufacturing/Production   |
| <input type="radio"/> Casino/Gaming                 | <input type="radio"/> Nonprofit Executive        |
| <input type="radio"/> Construction/Skilled Trade    | <input type="radio"/> Operations                 |
| <input type="radio"/> Creative/Design/Architectural | <input type="radio"/> Other:                     |
| <input type="radio"/> Defense/Military              | _____  |
| <input type="radio"/> Editorial/Writing/Publishing  | (Please write in your occupation)                |
| <input type="radio"/> Education                     | <input type="radio"/> Public Service             |
| <input type="radio"/> Elected Official/Embassy      | <input type="radio"/> Retail/Sales/Real Estate   |
| <input type="radio"/> Engineering/Science/R&D       | <input type="radio"/> Student                    |
| <input type="radio"/> Entertainment/Sports/Arts     | <input type="radio"/> Transportation/Warehousing |
| <input type="radio"/> Financial Services            |  |
| <input type="radio"/> Health Care Professional      |  |

**B**

Please choose all of your sources of income\* (Select all that apply)

Answer if **retired or not working**:

- Retirement Savings  
 Spousal Support  
 Social Security or Pension  
 Other Government Services  
 Other:

\_\_\_\_\_  
(Please write in all other sources)



**7 Choose where to put your money**

You can put your money in an investment and/or cash option. Future contributions and withdrawals will be allocated to help bring your account to your target allocation of cash and investment balances.

Please read the Washington State ABLE Savings **Plan Disclosure Booklet** for important information about the cash and investment options before making a decision.

**With an investment portfolio**

- This portion of your money is usually set aside for longer term investment.
- There is a risk of losing money, even your contributions, but you may also gain money over time.
- Each option has varying degree of risk, going up and down in value depending on the market.
- It can take up to 5 – 7 business days to receive money once you start a withdrawal.
- Learn about the three portfolio options, ABLE Conservative, ABLE Moderate, and ABLE Aggressive in the **Plan Disclosure Booklet** before you choose one in the next step.

**With an FDIC Savings Fund**

This portion of your money is usually set aside for short term saving or on-going spending needs.

- There's low risk, but minimal or no interest.
- The account is FDIC insured up to the allowable amount.
- It can take up to 3 – 5 business days to receive money once you start a withdrawal.

**Still undecided about the cash and/or investment allocation?**  
**Check out the question: “How transfers work?” in the FAQs section**  
**on [www.WashingtonStateABLE.com](http://www.WashingtonStateABLE.com) for more information.**

The investment information on this page has been provided by Sellwood Consulting, the investment advisor for the Washington State ABLE Savings Plan.





**8 Select Investment Option**

There are four investment options to pick from. There are risks involved in investing, your decision should be based on your goals and timeline for this ABLE account. The rest is up to the market's performance. Contributions must be made by the Beneficiary or the Authorized Legal Representative.

You can include a check made out to Washington State ABLE Savings Plan. You can select as many portfolios you want to invest your contributions. You can view your portfolio selections at any time or change your investment strategy up to twice per calendar year.

For an in-depth look at each of the investment options, please refer to the Plan Disclosure.

**How do you want to invest?** (Please select one)

**ABLE Conservative**

A predesigned diversified option with a mix of stocks and bonds for a more conservative risk profile.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**ABLE Moderate**

A predesigned diversified option with a mix of stocks and bonds for a more moderate risk profile.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**ABLE Aggressive**

A predesigned diversified option with a mix of stocks and bonds for a more aggressive risk profile.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**Cash Option**

This fund offers FDIC insurance protection for amounts contributed up to FDIC-permitted limits.

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

\$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Total contribution amount**

The investment information on this page has been provided by Sellwood Consulting, the investment advisor for the Washington State ABLE Savings Plan.



**9 Successor Designated Beneficiary information – optional**

This information is needed to confirm the Successor Designated Beneficiary’s eligibility for this ABLE account. The Successor Designated Beneficiary is eligible to inherit the account if the Beneficiary dies or becomes incapacitated. By law, a Successor Designated Beneficiary for an account must be a sibling, step-sibling, or half-sibling of the designated beneficiary, and must also have a qualifying disability.

\_\_\_\_\_  
**Successor Designated Beneficiary name** (First and last)

\_\_\_ / \_\_\_ / \_\_\_\_\_  
**Date of birth** (mm/dd/yyyy)

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
**Social Security** or **Taxpayer Identification Number**

\_\_\_\_\_  
**Street address 1**

\_\_\_\_\_  
**Street address 2**

\_\_\_\_\_  
**City**

\_\_\_\_\_  
**State**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
**Zip Code**

**Which option applies to the Successor Designated Beneficiary?** (Please select one)

I certify under the penalties of perjury that:

- The Successor Designated Beneficiary is entitled during the current year to Social Security Disability (SSDI) benefits based on blindness or disability under title II of the Social Security Act.
- The Successor Designated Beneficiary is entitled during the current year to Supplemental Security Income (SSI) benefits based on blindness or disability under title XVI of the Social Security Act.
- The Successor Designated Beneficiary
  - a.** has a medically determinable physical or mental impairment that results in marked and severe functional limitation\* and can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; OR is blind†
  - AND**
  - b.** has a signed diagnosis (see our Physician’s Form) from a licensed physician‡ as to the condition described in (a)

I understand that I am required to retain such signed diagnosis and to provide it to the Program or the IRS upon request, and I agree to do so.

\* I understand that “marked and severe functional limitation” means a functional limitation that meets, medically equals, or functionally equals the severity of any listing in appendix 1 of subpart P of 20 CFR part 404 (the “Listing”), but without regard to age. The Listing can be found at: <https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P?toc=1>. I further understand that the level of severity is determined by taking into account the effect of the Beneficiary’s prescribed treatment.

† I understand that, for purposes of eligibility for an ABLE account, “blind” means that the Beneficiary has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

‡ Must be a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who is legally authorized to practice medicine and surgery by the state in which s/he performs the diagnosis. The full IRS listing of acceptable medical sources can be found at: [https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502\(a\)](https://www.ecfr.gov/current/title-20/chapter-III/part-404/subpart-P#p-404.1502(a)).



continued from page 9

**Diagnosis Code** (Please select one)

- Code 1: Developmental Disorder**  
Autistic Spectrum Disorder, Asperger’s Disorder, Developmental Delays and Learning Disabilities
- Code 2: Intellectual Disability**  
Mild, moderate, or severe intellectual disability
- Code 3: Psychiatric Disorder**  
Schizophrenia, Major depressive disorder, Post-traumatic stress disorder (PTSD),  
Anorexia nervosa, Attention deficit/Hyperactivity disorder (AD/HD) and Bipolar disorder
- Code 4: Nervous Disorder**  
Blindness, Deafness, Cerebral Palsy, Muscular Dystrophy, Spina Bifida, Juvenile-onset Huntington’s disease,  
Multiple sclerosis, Severe sensorineural hearing loss and Congenital cataracts
- Code 5: Congenital Anomalies**  
Chromosomal abnormalities: Down Syndrome, Osteogenesis imperfecta, Xeroderma pigmentosum,  
Spinal muscular atrophy, Fragile X syndrome and Edwards syndrome
- Code 6: Respiratory Disorder**  
Cystic Fibrosis
- Code 7: Other**  
Anything not listed under codes 1-6 and Tetralogy of Fallot, Hypoplastic left heart syndrome,  
End-stage liver disease, Juvenile-onset rheumatoid arthritis, Sickle cell disease and Hemophilia

**Is this disability permanent\*?**     Yes     No

**I certify under the penalties of perjury that:**

- The Successor Designated Beneficiary developed the disability or blindness before the age of 26
- I will notify the Program of any changes to the permanence\* of the Successor Designated Beneficiary’s disability or blindness (including any potential cure for such disability or blindness) promptly upon such an occurrence.
- The Successor Designated Beneficiary is a sibling, step-sibling, or half-sibling of the Designated Beneficiary.

\_\_\_ / \_\_\_ / \_\_\_\_\_  
**Certification date** (mm/dd/yyyy)

\* Permanent/permanence is intended to mean a disability that “can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months” as set forth in Section 529A of the Internal Revenue Code.



**10 Bank account information**

Attach a voided check or copy of your bank statement showing the name, address, the account number and complete the bank information below. (Please do not staple, use a paper clip for the check).

What type of documentation are you including to verify this bank account?

Voided Check

Bank statement

Bank account type       Checking       Savings

**Name on bank account**

The first and last name on the bank account needs to be the same as either the Beneficiary or the Authorized Legal Representative.

\_\_\_\_\_  
Bank name

\_\_\_\_ \_  
Bank routing number

\_\_\_\_\_  
Bank account number

**Need help?**

You can find your bank information on the bottom of one of your checks here:

A000000000 A 0000000000000000 c 1000

Routing Number	Account Number
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**11 Initial Contribution Information**

- Check (Please include a check made out to Washington State ABLE Savings Plan with a paper clip, do not staple)
- ACH deposit (Please fill out Step 10)

Which type of contribution are you making? (Please select one)

- Standard contribution**  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution**  
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see Program Disclosure Booklet for current limits), in addition to the yearly standard contribution limit.\*

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions.



**12 Monthly contribution information — If applicable**

Skip this step if you don't want to set up a monthly contribution at this time. You can set up monthly contributions in the future online.

By setting up a monthly contribution, this will authorize us to initiate recurring ACH debits (direct withdrawals) from your bank account on the day you indicate of each month for the amount you set. You may cancel or change these recurring ACH debits (direct withdrawals) online or by using the **Manage Monthly Contributions** Form; however, we must receive your request at least 3 business days before you want it to become effective. We will continue to process transactions scheduled to occur before the end of the 3rd business day after you tell us to stop.

**How do you want to invest?** (Please Select at least one)

**ABLE Conservative** \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**ABLE Moderate** \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**ABLE Aggressive** \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

**Cash Fund** \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Amount** (per pay period)

\_\_\_\_\_  
**Contribution Day** (1-28)\* \$ \_\_\_\_\_ , \_\_\_\_\_ . \_\_\_\_\_  
**Total contribution amount**

If you don't pick a date, we'll automatically deduct you contribution on the 1<sup>st</sup> of every month

Which type of contribution are you making? (Please select one)

- Standard contribution**  
See the Program Disclosure Booklet for the current yearly standard contribution limit.
- ABLE to Work contribution**  
If the Beneficiary is earning wages, they may contribute an amount equal to their gross income, up to current limits (see Program Disclosure Booklet for current limits), in addition to the yearly standard contribution limit.\*

\* A note on when contributions will be deducted from your bank account: If the Contribution Day you've selected falls on a regular business day, your contribution will be deducted from your bank account two business days prior to the Contribution Day. If the Contribution Day you've selected falls on a weekend or a holiday, the contribution will be deducted from your bank account on the next Business Day.

\* If the Beneficiary or their employer is contributing to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year, the Beneficiary is not eligible to make ABLE to Work contributions.



**13 Identification**

We need any individuals linked to this account over the age of 18 to provide identification.

**How to provide identification**

- If you are the Beneficiary, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary is under 18**, please include Acceptable ID Documentation for yourself
- If you are the Authorized Legal Representative **and the Beneficiary is over 18**, please include Acceptable ID Documentation for yourself and the Beneficiary

<p><b>Acceptable ID Documentation</b></p> <p><b>Option A</b> Include a copy of a Department of Motor Vehicles State ID</p> <p><b>Option B</b> Include a copy of both your Social</p>
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To help the government fight the funding of terrorism and money laundering, federal law requires us to obtain certain personal information, including your name, address, date of birth, and Social Security number or taxpayer identification number and other information that will allow us to verify your identity. If we are unable to verify your identity, we may have to close your account or take other steps we think are necessary.



**13 Sign the form**

By signing below, I am agreeing to the terms and conditions set forth below and in the **Program Description & Participation Agreement**. I understand and agree that those documents govern all aspects of this Account and are incorporated herein by reference.

I will retain a copy of the **Program Description & Participation Agreement** for my records. I understand that the Washington State ABLE Savings Plan program may, from time to time, amend the **Program Description & Participation Agreement**, and I understand and agree that I will be subject to the terms of those amendments.

I certify that all of the information provided by me on this **Enrollment Form** is, and all information provided by me in the future will be, true, complete and correct and I authorize the Program to open this Account based upon this information.

Additionally, I certify under penalty of perjury:

- The Beneficiary’s disability or blindness is expected to result in death or has lasted, or can be expected to last for a continuous period of not less than 12 months and that I will notify the Program of any change to the status of the beneficiary’s disability or blindness (including any potential cure or remission of such disability or blindness) promptly upon such occurrence.
- I’m either a parent, a legal guardian, or have Power or Attorney, which makes me an Authorized Legal Representative. I am authorized to act on the Beneficiary’s behalf in opening the Account and that this Account is in the best interest of the Beneficiary.
- If I’ve indicated that either my initial contribution or monthly contributions are ABLE to Work contributions I certify that the Beneficiary is earning wages and the amount being contributed is less than or equal to the Beneficiary’s gross income this calendar year and is no more than the current limits (see Program Disclosure Booklet for current limits). I also certify if I’m making an ABLE to Work contribution that the Beneficiary (or the Beneficiary’s employer) has not contributed to a defined contribution plan (401K), annuity plan (403(b)), or deferred compensation plan (457(b)) this calendar year.

\_\_\_\_\_  
**Signature of Beneficiary or Authorized Legal Representative**

\_\_\_/\_\_\_/\_\_\_\_\_  
**Date (mm/dd/yyyy)**