Washington State
ABLE SAVINGS PLAN

Remove Authorized Legal Representative Form

Important information about opening a new account:

- Use this form if the adult Beneficiary has reached the age of 18 and wishes to exercise signature authority and assume administrative duties on the account.
- If the Beneficiary is under the age of 18, please complete **a Change Authorized Legal Representative Form** instead.
- 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 the Bank Add/Change Request Form** to make updates to the banking information if it's affected by removing the Authorized Legal Representative.
- The adult Beneficiary must provide a notarization acknowledgement.
- Type or print clearly in black ink, and do not staple the pages.

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

1 ABLE account information

____
Name of Beneficiary on the ABLE Account (First and last)

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Beneficiary's Social Security or **Taxpayer Identification Number**

___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Washington State ABLE Savings Plan account number

2 Beneficiary information

__ __ / __ __ / __ __ __ __
Date of Birth (mm/dd/yyyy)

___ ___ ___ - ___ ___ - ___ ___ ___ ___
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**

3 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)

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

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

4 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**:

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

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)

5 Verify your identity

The Beneficiary must provide identification to prove their identity if they reached the age of 18 since opening the account.

How to provide identification

Acceptable ID Documentation

Option A
Include a copy of a Department of Motor Vehicles State ID

Option B
Include a copy of both your Social

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.

6 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 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 of Attorney, which makes me an Authorized Legal Representative. I am authorized to act on the Beneficiary's behalf in opening and managing the Account and that this Account is in the best interest of the Beneficiary.

The Authorized Legal Representative must sign below. The adult Beneficiary must sign below unless they have become incapacitated, in which case the Authorized Legal Representative must provide proof to the Guarantor signing a notarization acknowledgement in **Step 9**.

____ __ __ / __ __ / __ __ __ __

Signature of Authorized Legal Representative **Date** (mm/dd/yyyy)

____ __ __ / __ __ / __ __ __ __

Signature of adult Beneficiary — If applicable **Date** (mm/dd/yyyy)

7 A notarization acknowledgement is required for a Authorized Legal Representative

Keep in mind that:

- If I am an Authorized Legal Representative, I certify that I am authorized to act on behalf of the Account Owner or the Beneficiary in making this request and that this request is in the best interest of the Beneficiary.
- By signing below, I authorize the Plan Manager or its designee to change the address according to the instructions above.

Only sign if you are in the presence of a notary public or other officer providing notarization.

The undersigned has read the foregoing in its entirety before signing. IN WITNESS WHEREOF, I have hereunto

set my hand this ______ day of ______________________ , 20_____
Day (#) Month Year

____

Signature of Beneficiary or Authorized Legal Representative

STATE OF WASHINGTON, COUNTY OF ____
County

This instruction was acknowledged before me

☐ physical presence or ☐ online notarization

on ______ day of ______________________ , 20_____
Day (#) Month Year

by ____
Name of person (first and last)

My term expires: __ __ / __ __ / __ __ __ __
Date (mm/dd/yyyy)

Notary Public (Seal)

____

Signature of Notary Public