Washington State ABLE SAVINGS PLAN

Add/Edit/Remove Successor Designated Beneficiary Form

Important information about this form:

- Before completing this form, carefully read the Plan Disclosure Statement & Participation Agreement.
- Fill out this form to add, edit, or remove a Successor Designated Beneficiary from an Washington State ABLE Savings Plan 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 Washington State ABLE Savings Plan account must be a sibling, step-sibling, or half-sibling of the designated beneficiary, and must also have a qualifying disability.
- If something happens to the Beneficiary, the Successor Designated Beneficiary should contact customer service to assume the responsibility for the account. They will need to provide legal documentation (e.g. Death Certificate or other legal documents), as well as proof of their eligible disability.

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 9892
Providence, RI 02940-8092

Overnight Mail:
Washington State ABLE Savings Plan
4400 Computer Drive
Westborough, MA 01581

Want to enroll faster?
Go online to WashingtonStateABLE.com

1 Washington State ABLE account information

_____
Name of the Beneficiary on the Washington ABLE account (First and last)

___ ___ ___ – ___ ___ – ___ ___ ___ ___
Beneficiary's Social Security or Taxpayer Identification Number

W A – ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Washington ABLE account number

2 Manage Successor Designated Beneficiary information

(Please select one)

- ◯ Add a Successor Designated Beneficiary
- ◯ Change the Successor Designated Beneficiary
- ◯ Remove the Successor Designated Beneficiary (Skip to **Step 4**)

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3 Successor Designated Beneficiary information

This information is needed to confirm the Successor Designated Beneficiary's eligibility for this Washington State ABLE account.

_____

Successor Designated Beneficiary name (First and last)

__ __ / __ __ / __ __ __ __

Date of birth (mm/dd/yyyy)

__ __ __ – __ __ – __ __ __ __

Social Security or Taxpayer Identification Number

Residential address

No P.O. boxes are accepted for a residential address.

_____

Street address 1

_____

Street address 2

_____

City

_____ __ __ __ __ __ – __ __ __ __

State **ZIP Code**

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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 limitations* 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 Plan 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).

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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 46.
- ◯ 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.

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4 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **Plan Disclosure Statement & Participation Agreement**. I understand and agree that those documents govern all aspects of this Washington State ABLE Savings Plan account and are incorporated herein by reference.

I will retain a copy of the **Plan Disclosure Statement & Participation Agreement** for my records. I understand that the Washington State ABLE Savings Plan may, from time to time, amend the **Plan Disclosure Statement & 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 change this Washington State ABLE account based upon this information.

Signature of Beneficiary or Authorized Legal Representative

Date (mm/dd/yyyy)