



Important information about this form:

- 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.
- There can only be one Authorized Legal Representative managing an account at any time.
- Fill out the **Bank Add/Change Request Form** to make updates to the banking information regarding the Authorized Legal Representative — if applicable.
- A notarization acknowledgement is required for the Authorized Legal Representative and the adult Beneficiary. If the Beneficiary has become incapacitated, proof will be required instead of a signature.
- 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 15253-4431

1 ABLE account information

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

____ _ — ____ _ — ____ _
Beneficiary’s Social Security or Taxpayer Identification Number

____ _ — ____ _ — ____ _
Washington State ABLE Savings Plan account number

2 Reason for adding Authorized Legal Representative

(Please select one)

- Adult Beneficiary has selected an Authorized Legal Representative to manage the account (Signatures are required for the Authorized Legal Representative and the adult Beneficiary in **Steps 7 – 9**)
- Adult Beneficiary has become incapacitated since opening the account (The Authorized Legal Representative’s signature and proof of incapacitation are required in **Steps 7 – 9**)

If the account already has an Authorized Legal Representative, please complete a Change Authorized Legal Representative Form instead.



3 Authorized Legal Representative information

If an Authorized Legal Representative is managing the account for a Beneficiary over the age of 18, they must also complete a **Verify Relationship Form** in addition to this form.

Name (First and last)

Relationship to the Beneficiary (Please select one)

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

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

___ / ___ / _____
Date of birth (mm/dd/yyyy)

___ - ___ - _____
Social Security or Taxpayer Identification Number

___ - ___ - _____
Telephone number

Residential address

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

Street address 1

Street address 2

City

State

ZIP Code



4 Communication preferences

Mailing address

P.O. boxes are accepted for a mailing address.

- 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 \$20 per account, per year)

- **4A** **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.



5 Work information of Authorized Legal Representative

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

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



6 Verify your identity

The Authorized Legal Representative must provide identification.

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 Security card and your birth certificate

To help the government fight the funding of terrorism and money laundering, federal law requires us to obtain certain personal information: 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.



7 Sign the form

By signing below, I am agreeing to the terms and conditions set forth below and in the **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 **Plan Disclosure** for my records. I understand that the Washington State ABLE Savings Plan may, from time to time, amend the **Plan Disclosure** and the **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 Plan to make changes to my account 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 Plan 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.
- As the new Authorized Legal Representative, I certify that I have authority to act as the Beneficiary’s Authorized Legal Representative on this ABLE account. I understand that only certain persons can serve as an Authorized Legal Representative, and that there is an order of priority for who can serve. Specifically, I understand that the order of priority is: (1) a person selected by the Beneficiary (when the Beneficiary also has legal capacity), (2) the Beneficiary’s agent under power of attorney, (3) conservator or legal guardian, (4) spouse, (5), parent, (6) sibling, (7) grandparent, or (8) a representative payee appointed for the Beneficiary by the Social Security Administration. I certify that I am qualified under this prioritized list to serve as the Beneficiary’s Authorized Legal Representative, and that there is no other person higher than me on the prioritized list who is both willing and able to serve as the Beneficiary’s Authorized Legal Representative on this account. I further certify that: (1) this account is in the best interest of the Beneficiary; (2) that I neither have, nor will I acquire, any beneficial interest in the Beneficiary’s ABLE account during the Beneficiary’s lifetime; and (3) that I will administer the ABLE account for the benefit 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 Plan along with this form.

Signature of Authorized Legal Representative

Date (mm/dd/yyyy)

Signature of adult Beneficiary — If applicable

Date (mm/dd/yyyy)



9 A notarization acknowledgement is required for an adult Beneficiary — If applicable

If the adult Beneficiary has become incapacitated, the Authorized Legal Representative must provide proof to the Plan along with this form.

Keep in mind that:

- You're providing the following information as underwritten certification that your signature is genuine.
- You cannot guarantee your own signature. You may be required to provide proof of your authority to act on behalf of the ABLE account.

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

State of Washington, County of _____

This instrument was acknowledged before me

physical presence online notarization

on _____
Date (mm/dd/yyyy)

by _____
Name of person (First and last)

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

Notary Public (Seal)

Signature of Notary Public