



Important information about this form:

- 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 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 Beneficiary information

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

___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
Telephone number

Residential address

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

Street address 1

Street address 2

City

State

___ ___ ___ - ___ ___ ___ ___
ZIP Code



3 Communication preferences

Mailing address

P.O. 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 3A** below)
- Send digital quarterly statements and account information by email, but send tax forms by U.S. mail* (Please answer **Step 3A** below)
- Send quarterly statements, account information and tax forms by U.S. mail*
(You'll be charged \$20 per account, per year)

- **3A** **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 of the Beneficiary

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

What is the Beneficiary'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 | _____ |
| <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)



5 Verify your identity

The Beneficiary must provide identification 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 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.



6 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 change 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 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.

The adult Beneficiary must sign below and must provide a notarization in Step 7.

Signature of adult Beneficiary

Date (mm/dd/yyyy)



7 A notarization acknowledgement is required

- By signing below, I authorize the Plan Manager or its designee to remove the current Authorized Legal Representative and appoint the Beneficiary as the signatory and manager 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